Sierra Leone

National HIV Behaviour Change Communication & Advocacy Strategy 2011-2015

March 2012

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LIST OF TABLES AND FIGURES

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
AWP	Annual Work Plan
BCAASL	Business Coalition Against Aids in Sierra Leone
BCC	Behavioural Change Communication
BSS	Behaviour Surveillance Survey
CAC	Chiefdom AIDS Committee
CBO	Community Based Organisation
CCM	Country Coordination Mechanism
COPSAASL	Coalition of Public Sector Against HIV and AIDS in Serra Leone
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DAC	District AIDS Committee
DPC	Disease Prevention and Control
EID	Early Infant Diagnosis
ETWG	Extended Technical Working Group
FP	Family Planning
FSU	Family Support Unit
GF	The Global Fund on HIV/AIDS, TB and Malaria
GoSL	Government of the Republic of Sierra Leone
GWT	Gender Working Team
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HR	Human Rights
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMC	Independent Media Commission
INGO	International Non Governmental Organization
JPR	Joint Programme Review
KYE,KYR	Know Your Epidemic, Know Your Response
Le	Leone (Sierra Leone currency)
MARPs	Most-at-Risk Populations
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoHS	Ministry of Health and Sanitation
MoT	Modes of Transmission
MoU	Memorandum of Understanding
MoYS	Ministry of Youth and Sports
MSM	Men who have Sex with Men
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NAC	National AIDS Council

NACP	National AIDS Control Programme
NACSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NETHIPS	Network of HIV Positives
NGO	Non-governmental Organization
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHE	Public Health Educators
PHU	Peripheral Health Units
PIHCT	Provider Initiated HIV Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSO	Private Sector Organization
RST	Regional Support Team
SL	Sierra Leone
SLDHS	Sierra Leone Demographic and Health Survey
SLIRAN	Sierra Leone Inter-religious AIDS Network
SLYCHA	Sierra Leone Youth Coalition on HIV and AIDS
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TTI	Transfusion Transmitted Infections
TWG	Technical Working Group
UCC	UNAIDS Country Coordinator
UCO	UNAIDS Country Office
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nation General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UNIDO	United Nations Industrial Development Organization
UNIPSIL	United Nations Integrated Peace Building in Sierra Leone
USP	Universal Safety Precautions
WHO	World Health Organization

FOREWORD

The National HIV/AIDS Secretariat is pleased to present this ***National HIV/AIDS Behaviour Change Communication and Advocacy Strategy*** to our key strategic partners as a tool for undertaking advocacy towards behavior change for preventing new HIV infections, uptake of treatment and reducing HIV-related stigma and discrimination in Sierra Leone. This is our second Behaviour Change Communication Strategy, but the first to incorporate elements of Advocacy. Advocacy towards behaviour change in preventing HIV and dealing with HIV-related stigma and discrimination is essential at all levels.

Experience shows that with the low prevalence rate, society continues to stay in denial and miss out on arresting the epidemic from spreading. As HIV affects the most productive segment of our population, it is very important for all of us to undertake focused advocacy and behavioural change efforts with key members of our society. We appreciate the exemplary courage and bold steps taken by our PLHIV community in disclosing their status and sharing their personal stories of rejection and courage to live with the virus.

The National HIV/AIDS Secretariat strongly believes in the principles of multi-sectorality and partnership. Our collaboration with partners is our top-most strength that we can rely on as an effective strategy to advocate and communicate on HIV/AIDS prevention, treatment, care and support.

Our ***National HIV/AIDS Behaviour Change Communication and Advocacy Strategy*** provides a simple and practical framework to plan and conduct advocacy and training sessions aimed at ensuring behavior change towards HIV/AIDS issues. I am sure the availability of this strategy will certainly help our strategic partners to follow more structured process in communicating on HIV/AIDS issues.

Regard this Document as belonging to all of us engaged in the HIV/AIDS work. We need your feedback to constantly reshape our strategy so that it will be of maximum use to all of us.

This Strategy will become an integral tool of Our National HIV/AIDS Strategic Plan 2011 – 2015, which we launched on December 1, 2010 as part of our commitment to the Global Vision of Zero new HIV Infections, Zero AIDS related Deaths and Zero Stigma and Discrimination by 2015. Let us get the momentum going and see where it leads us.

Dr. Brima Kargbo, GOOR

Director, NAS

Acknowledgements

This National HIV Behaviour Change Communication and Advocacy Strategy represent Government's continued effort and commitment to achieving Zero New HIV Infections in Sierra Leone by 2015. Many individuals from various institutions who provided information and relevant data informed the writing of this strategy. Such wealth of information will no doubt be tremendously useful in charting our roadmap to achieving Zero new HIV infections and meeting the Universal Access Targets for Sierra Leone. We would like to acknowledge their contributions and shared experiences to the entire process.

We are grateful to the National Consultants, Messers Dominic Lamin and Kalilu Totangi who facilitated the compilation of information and discussions by displaying enormous tact, determination and attention to detail. We would like to thank all the stakeholders they interviewed and those who contributed information during the drafting and finalization of this strategy.

We offer our personal thanks to the team established to guide and to serve as source of ideas and support to the entire process. Specifically, we would like to thank the National HIV/AIDS Secretariat Staff, Messers Abdul Rahman Sessay and Abu Bakarr Koroma, the UNAIDS staff Mr. Chibwe Lwamba, Ms. Helen Lane and Ms. Aki Yoshino, and Mr. Edmond Makiu from UNICEF..

We are also grateful to the UN Family in Sierra Leone and the sub-Region who contributed their time and effort in providing ideas to finalize this BCC and Advocacy Strategy.

This Strategy would not have been possible without generous financial and other support from UNICEF. We appreciate the Agency's continued support to strengthening our national response to HIV/AIDS.

1.0 Introduction

Sierra Leone is located on the west coast of Africa and covers an area of about 71,740 square kilometres (approximately 28,000 square miles). The country is bordered on the north and northeast by the Republic of Guinea, on the south and southeast by the Republic of Liberia and the west and southwest by the Atlantic Ocean. Administratively, the country is divided into four regions namely; the Western Area, the Northern, Southern and Eastern provinces. The provinces are further divided into fourteen (14) Districts and 149 chiefdoms. The 14 Districts are sub-divided into 19 Local councils following the enactment of the Decentralization Act.

The 2004 Population and Housing Census estimated the country's population at 4,976,871 with 37.1% residing in urban areas. The results of the previous censuses indicated an annual population growth rate of 1.8% per annum during the 1985-2004 periods. Women account for about 51.5% of the total population with 47.8% of the estimated total population within the age brackets of 15 – 49 years. The Total Fertility Rate (TFR) has remained at slightly above 6 children per woman and this rate has remained constant for over a decade. This high TFR level has largely contributed to the youthful nature of the population. 47% of the population is under age 15 years and adolescents accounted for 19.4% of the estimated population in 2004.

The first case of HIV/AIDS in Sierra Leone was diagnosed in 1987 and currently the number of people living with HIV/AIDS is estimated at 50,000. The country adopted a multi-sectoral strategy in 2002 by establishing the National HIV/AIDS Secretariat (NAS) as the Secretariat for the National AIDS Council to provide policy and strategic direction including monitoring, mobilizing, managing and coordinating partners and resources engaged in the response.

From the outset of the multi-sectoral strategy in 2002, prevention of HIV transmission remains the most important priority of the national response. The key aspect of which has been the mobilization of society. In this regard, the Government of Sierra Leone has just commenced the implementation of the second National Strategic Plan on HIV/AIDS 2011 – 2015 with aims at ***Zero New HIV Infections by 2015.*** This is the second multi-sectoral response strategic plan and the first comprehensive results-based strategic plan on HIV/AIDS that aligns HIV prevention interventions resources to sources of new infections. The key prevention interventions in this strategic plan is to ensure a significant increase in the number of young adopting key HIV prevention behaviours, virtual elimination of vertical transmission of HIV and ensuring safe blood transfusion practices throughout the country.

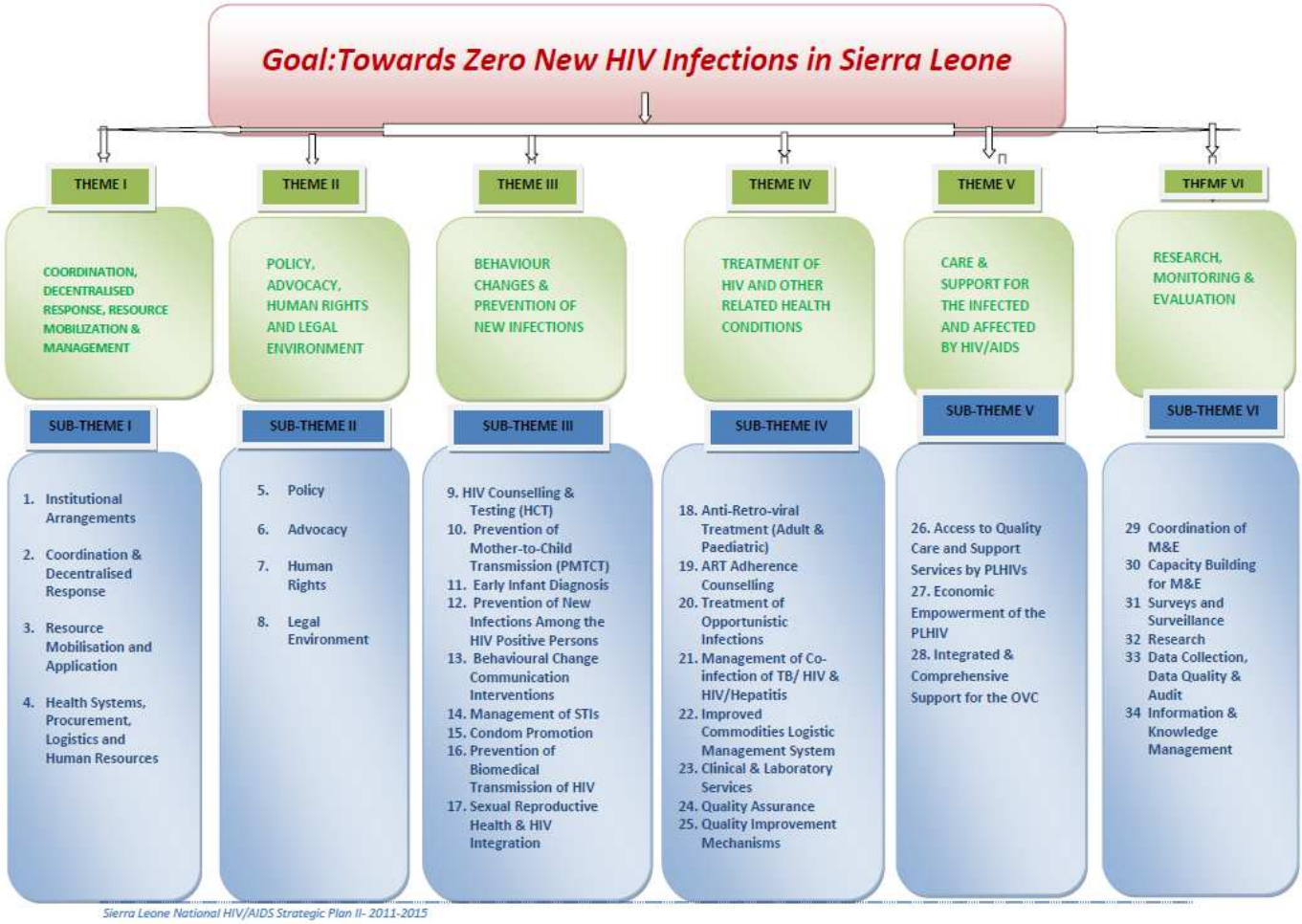
The implementation of the country's first multi-sectoral Strategic Plan on HIV/AIDS 2006 – 2010 through the support from partners has resulted to the country witnessing stability in HIV prevalence among the general population. Since 2005 the national prevalence rate of HIV among the general population has remained at 1.5%. There are signs of declining HIV prevalence among antenatal clinic attendees from 3.5% in 2008 to 3.2% in 2010.

Despite this progress, the number of new HIV infections on an annual basis currently estimated at 5,844 outstrips by far, the AIDS-related mortality and annual enrolment into antiretroviral therapy (ART) [1]. The existing behavioural and structural HIV prevention interventions in the country still fall short of the universal target in terms of both coverage and access to services. The sudden emergence of most-at-risk populations like men having sex with men (MSM), Intravenous Drug Users (IDUs) that are new phenomena to the Sierra Leone society without a targeted and re-invigorated prevention interventions, the gains already made in scaling up HIV/AIDS treatment and care and blood transfusion interventions in recent years are likely to be eroded. Comprehensive knowledge of HIV prevention and in particular condom use in the population is still very low. The achievement of the MDG on HIV/AIDS and long-term sustainability of the national response require an intensified and increased effectiveness of HIV prevention.

The 2011 – 2015 National Strategic Plan on HIV/AIDS – ***Towards Zero New Infections in Sierra Leone by 2015*** charts the roadmap towards an accelerated HIV Prevention effort by Government supported by development partners and various stakeholders involved in the national response. The National HIV BCC and Advocacy Strategy is aligned with the HIV prevention goals and targets set in the 2011 – 2015 National Strategic Plan on HIV/AIDS; the Government's Agenda for Change (PRSP II); international development frameworks such as Millennium Development Goals 4, 5 and 6; the UNGASS Declaration of Commitment and Universal Access commitments and targets. This BCC and Advocacy Strategy aims at revolutionising the country's HIV prevention efforts by increasing coverage and effectiveness of HIV prevention interventions. It is anchored on the 2010 HIV Modes of Transmission Study "Know Your Epidemic, Know Your Response". HIV prevention interventions are directed to sources of new HIV infections and population groups most at risk.

[1] Sierra Leone HIV Modes of Transmission Study "Know Your Epidemic, Know Your Response", August 2010, pp. 52

Figure 1: Sierra Leone's National Strategic Plan 2011-2015



Sierra Leone National HIV/AIDS Strategic Plan II- 2011-2015

1.1 Development of the National Behaviour Change Communication and Advocacy Strategy

This HIV and AIDS Behaviour Change Communication and Advocacy Strategy was developed by the National AIDS Commission (NAC) through the support and guidance of a Core Team (UNAIDS, NAS, UNICEF) and two local consultants.

The National AIDS Commission (NAC) is the national coordinating body responsible inter alia for the overall coordination and leadership of HIV and AIDS response in Sierra Leone. It carries out its functions by establishing and supporting key technical and coordinating bodies at various levels.

The primary goal of NAC is to reduce the spread of HIV and mitigate the impact of AIDS in Sierra Leone. The NAC has developed a National Strategic Plan 2011 - 2015, with a vision of recording 'zero new HIV infection by 2015". The NSP is evidence based, and was informed by findings based on secondary data review and primary source information and analysis from the Modes of Transmission Study done in 2010.

Prominent amongst the findings is the need for a robust communication strategy to address underlying cultural and behavioural factors influencing or causing a slow increase on behavioural indicators over the years. Studies show a high level of general awareness of HIV but a very low comprehensive knowledge of the epidemic in the general population. Condom use is low and the number of people that actually know their HIV status is also very low.

Over the years there have been several forms and types of information in different media. Yet these are sometimes conflicting and contradictory, thus creating confusion in the public and making some interventions counter-productive or even valueless.

The need for effective communication cannot be over emphasized and it cuts across all the objectives in the NSP. The NAC therefore places high priority on effective

communication as a means to achieving the goals of the NSP. It is therefore important to have a Communication Strategy that will give guidance to all stakeholders who wish to carry out communication activities in the area of HIV and AIDS.

The NSP has six priority areas. Success in each of the priority areas is contingent on effective communication. This Behavioural Change Communication (BCC) and Advocacy Strategy is intended to support the programmes and activities outlined in the NSP and it is based on the following guiding principles:

- Based on evidence and priorities
- Considers individuals, families and communities within their environment & from their perspective
- Takes into consideration the Social determinants of HIV and AIDS in a multi-sectoral fashion
- Considers relevant cultural, traditional and religious approaches & messages that address the existing levels of KAPBs
- It intervention are rights based
- Encourages and fosters full community participation
- Deals with realistic, measurable objectives & indicators
- Prepare for monitoring and reassessment of activities at every level

1.2 Goals and Objectives

In line with the National Strategic Plan on HIV 2011-2015, the **goal** of the BCC and Advocacy strategy is:

To increase the effectiveness, coordination and comprehensiveness of BCC and advocacy interventions on HIV in Sierra Leone by 2015.

The key **objectives** of the Strategy are to:

- Increase to 50% the percentage of persons with comprehensive knowledge of HIV
- Increase to 50% the percentage of young people adopting appropriate HIV and AIDS related behaviour
- Increase to 50% the percentage of MARPs reached with group-specific interventions and adopting appropriate HIV and AIDS related behaviour
- Increase the number of people who know their HIV status
- Increase correct and consistent condom use
- Reduce the number of sexual partners
- Delay sexual initiation and reduce cross generational sex
- Reduce incidences of HIV-related stigma and discrimination
- Reduce rate of new HIV infections among stable/monogamous relationships (Discordant couples)
- Reduce the rate of untreated STIs and STDs
- Increase the uptake of ART
- Reduce the rate of TB/HIV co-infection
- Increase the number of people blood safety precautions

1.2 The BCC Strategy Development Process

The development of this document has followed prescribed and well-defined practical, step-by-step methodology for developing a BCC strategy. Steps in implementation are suggested as part of the strategy when the strategic interventions will be operationalised.

1.2.1 *Development of the strategy/Methodology*:

- A formative BCC assessment was conducted by first compiling and reviewing secondary data from several HIV and AIDS related studies, including the DHS 2010, BSS 2004, HIV/AIDS Communications Strategy 2004, and the Modes of Transmission Studies 2010. To provide a clear understanding of the applications of BCC activities, consultations with in-country programmes was carried out identifying achievements, key challenges and priority actions in HIV and AIDS to date.
- A framework/matrix was developed based on the key interventions and programmatic goals as is in the NSP and Prevention Strategy, to capture key elements of the communication strategy. Emphasis was put on the **problem statement** and **factors influencing** the behaviours.
- As part of the development process a 4-day retreat for experts in communications was organized. Participants included staff that had major responsibility for implementing BCC and advocacy activities in their organizations. The core team and two local consultants did the development of draft strategy.
- Key informants interviews (KII) were conducted with key stakeholders using a predetermined guide/protocol
- A district stakeholders review and validation of the draft strategy was conducted to provide additional input for its finalization. Participants included District AIDS Focal Points and HIV/AIDS Regional Coordinators
- A second review and validation was conducted with the youth and young people who made inputs particularly relating to their cohort.

- A national validation of partners including PLHIV, MARPS, the Press, medical practitioners, communication experts and youths was conducted for final country validation.
- The draft document was circulated to international partners and communication experts for inputs/comments before finalization and printing.

1.3 Institutional Arrangement for Coordination

The National HIV BCC and Advocacy Strategy is an offshoot of the National HIV/AIDS Strategic Plan 2011 – 2015. The institutional framework for the coordination of the BCC and Advocacy Strategy shall be in line with the National HIV/AIDS Strategic Plan 2011 – 2015. The institutional framework for coordinating the strategy is presented in Annex 1.

1.3.1 National Level Coordination:

Pursuant to the National AIDS Commission Act, 2011 and, in line with the "Principles of Three Ones" the National AIDS Commission (NAC) is responsible inter alia for making policies and provide overall coordination and leadership for the AIDS response in Sierra Leone. It carries out its functions by establishing and supporting key technical and coordinating bodies at various levels.

Technical Committees and other consultative fora are created at national level to aid information sharing and resource mobilisation: Partnership forum and Technical Working Groups such as: Donor Partners Consultative Group on AIDS, Expanded Technical working Group, IEC/BCC Steering Committee, Monitoring and Evaluation Technical Working Group, Treatment Technical Working Group and Laboratory Technical Working Group are operative at national level.

1.3.2 Constituents Coordinating Entities

In addition to the structures mentioned above there are other Coordinating entities within the response that play critical roles in coordinating activities of the different constituencies within the national response. They include the following:

(i) ***Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPAASL), which*** serve as a coordination platform for public sector HIV interventions

(ii) ***The Network of HIV positives in Sierra Leone (NETHIPS),*** *which is* an umbrella organization for people living with HIV and comprises over 40 PLHIV support groups nationwide.

(iii) ***Business Coalition against AIDS in Sierra Leone (BCAASL)****,* an umbrella organization of private sector organizations involved in HIV response.

(iv) ***Sierra Leone Inter-religious AIDS Network (SLIRAN)*** responsible for the coordination of faith-based organizations (Muslim and Christian organizations) working on HIV/AIDS in Sierra Leone.

(v) ***HIV/AIDS Reporters Association (HARA)*** responsible for coordinating the activities of its members who are journalists reporting on HIV and AIDS issue

(vi) ***Sierra Leone Youth Coalition on HIV and AIDS (SLYCHA)*** responsible for the coordination of youth organisations involved in the AIDS response

1.3.3 *District Level Coordination*:

There are 19 District AIDS Committees and they are responsible for coordinating HIV response at the district levels, and their composition is multi-sectoral in nature comprising inter alia: The Mayor or Chairman of the Local Council, the District Medical Officer, representatives of MDAs at the district levels, PLHIV, Civil Society Representatives, implementing partners and Women's and Youth groups. Their responsibilities as stated in **Sections 6 and 7 of the NAC Act, 2011** include: developing the district HIV and AIDS response plan and supervising the activities of the Chiefdom AIDS Committees.

1.3.4 Chiefdom Level Coordination:

The NAC, with support from the DACs, shall establish 149 Chiefdom AIDS Committees (CACs). The composition and functions of the CACs are fully stated in **Section 9 of the NAC Act, 2011**. The Paramount Chief shall serve as Chairman and other members include the Chiefdom Speaker, Chiefdom HIV and AIDS Focal Person, the Community Health Officer and representatives each of traditional healers, Civil Society, PLHIV, NGOs and SLIRAN, amongst others. Their key function is to coordinate the activities of all bodies and persons implementing HIV and AIDS programmes in the chiefdoms.

2.0 Behaviour Change Communication and Advocacy Approaches

2.1 Theory of Communication

Communication is the conveying of messages verbally or non-verbally. Communication involves a sender, receiver and a channel of transmission. Listening is part of communication. In the communication process, it is imperative that the sender and receiver have the same understanding of the messages. Beneficiaries should be involved the objective and activities setting. Communication may be one-to-one, through mass media (radio, TV, Internet, newspapers) or group media (drama, storytelling, music and dance). All behaviour change theories and models include communication theories.

The earliest models of communication assume a relatively linear process whereby someone sends a message to someone else via a channel and gets a response or feedback. This exchange process may occur on equal levels. But when the initiative and ability is overwhelmingly with the sender, the result is an impersonal, one-way flow of messages. This is often the case with mass communication when the media creates and sends messages with few opportunities for feedback from audience members and seldom via the same channels.

2.2 Behaviour Change Communication

The interest in the role of theories in behaviour change is not new. It has gained momentum in recent years. These theories originated from the works of behaviourists such as Skinner in the 1950's. The recent studies on the theories and models of behaviour change were conducted between 1970 and 1980. The most used theories are the social cognitive theory, theory of reasoned action and planned behaviour trans-theoretical model and the health belief model.

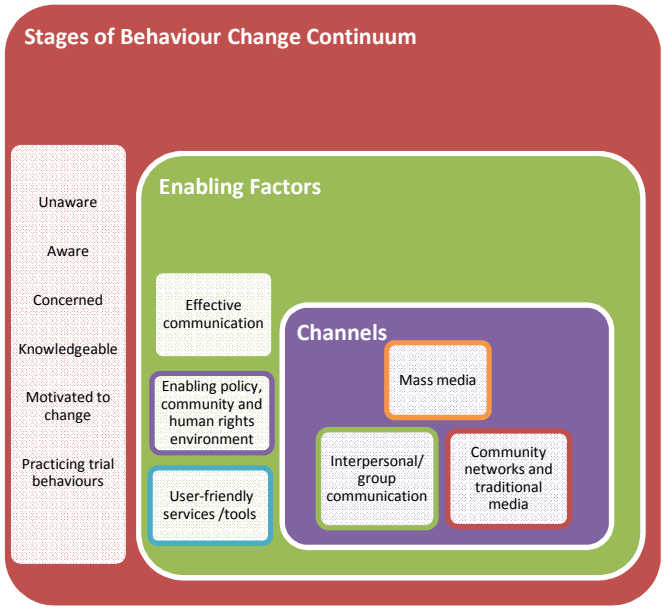
The paradigm shift to these theories is justified by the fact that they have proven to be effective in changing and maintaining behaviours in many areas such health, education, market consumption, criminology, etc.

According to Family Health International (FHI), ***Behaviour Change Communication (BCC) is an interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches with the aim of developing positive behaviours, promoting and sustaining individual, community and societal behaviour change, and maintaining appropriate behaviours.*** FHI further defines Behaviour Change Intervention (BCI) as being a combination of activities/interventions tailored to the needs of a specific group and developed with that group to help reduce risk behaviours and vulnerability to HIV by creating an enabling environment for individual and collective change. ***Information, Education and Communication (IEC) consists of communication strategies and support materials, based on formative research and targeted at influencing behaviours among specific groups.***

According to FHI, effective BCC can: Increase knowledge; stimulate dialogue within communities; promote attitudinal and behavioural change; reduce stigma and discrimination; create a demand for information and services; advocate to policy and decision-makers; promote services for prevention, treatment, care and support, and can improve skills and confidence among target population.

FHI describes the process or stages of behaviour change from being unaware to practicing the newly learned behaviours. This process is not always linear; individuals, communities or institutions may move backwards and forwards, or skip stages at various times. However knowing where the majority of the group is on the continuum is key to deciding upon a BCC strategy.

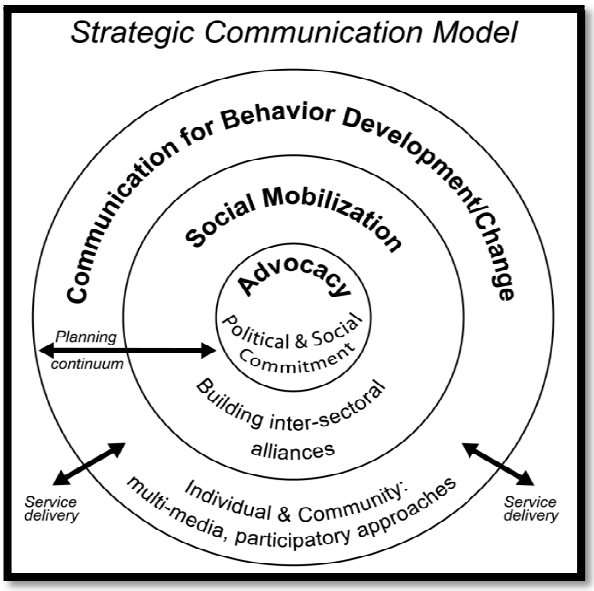
Figure 2: The Behaviour Change Communication Process



According to the John Hopkins Communication Model, for any HIV Behaviour Change Communication (BCC) and Advocacy Strategy to be effective, it must be complete and comprehensive, and spanning the range of issues from prevention to support services. Another approach that is common is the Strategic Communication Model. This approach emphasizes that a BCC and Advocacy strategy must be research-based and audiences-segmented, multi-channelled and of technically high quality. It should also be client-centred & participatory, where service-linked and results-oriented to scale up and should be sustainable. Its integrated approach embraces

advocacy as a means of building political and social commitment, social mobilization to build inter-sectoral alliances and BCC dealing with individual and community multimedia and participatory approaches.

Figure 3: The Strategic Communication Model of BCC



African approaches of Behaviour Change Communication (BCC) have emerged, as an amalgamation of both theories. According to this approach, BCC and advocacy should be implemented through various channels— through interpersonal communication (IPC) between a client and a health provider, through IPC to raise the awareness of decision makers on FP/RH issues, through social mobilization at the community level, through training to improve providers' behaviours and through youth group discussions on reproductive health and life skills.

This BCC and Advocacy strategy takes on board elements of most of the approaches mentioned above. The overriding priority in our combined approach is to increase knowledge through the provision of basic facts through accessible media, and the stimulation of community dialogue and broader dialogue on these facts and the driving factors of the epidemic. It is hoped that such discussions could discourage risky behaviours and stimulate discussions on health-seeking behaviours.

2.3 Advocacy

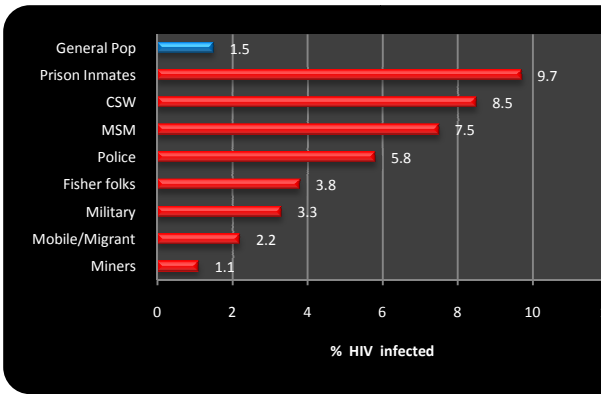
Advocacy can take many shapes and forms and there are many competing views of what the purpose of advocacy is and how it should be done; from policy advocacy to feminist advocacy to people-centred advocacy. For the purposes of this national strategy, taking a broad perspective and drawing on a definition by Oxfam and the Advocacy Institute, ***"advocacy may be understood as organised efforts and actions...which aim to highlight critical issues that have been ignored and submerged, to influence public attitudes and to enact and implement public laws and policies so that visions of 'what should be' in a decent and just society become a reality"***

2.4 Guiding Principles in Developing a BCC and Advocacy Strategy

a. BCC should be **integrated** with program goals from the start
b. **Formative BCC assessments** must be conducted to improve understanding of the barriers and opportunities for behaviour change
c. The **target populations** should participate in all phases of BCC and advocacy development
d. **Stakeholders** should be involved from the design phase
e. A variety of **communication channels** is more effective than one
f. **Pre-testing** is important for producing effective BCC materials
g. **Monitoring and evaluation** should be planned for from the start
h. BCC strategies should be **action-oriented and positive**
i. **PLHIV** should be **involved** in BCC and advocacy planning and implementation

3.0 Situational Analyses: the HIV Epidemic in Sierra Leone, the Media and BCC

Figure 4: HIV Prevalence by Various Population Sub-Groups



The first case of AIDS in Sierra Leone was reported in 1987. Between 2002 and 2005 the incidence of HIV increased from 0.9% to 1.5% among the 15 -49 age group and has since stabilized at this level (DHS 2009). The prevalence for men was estimated at 1.2% while that for women was 1.7%. There were no consistent patterns of HIV prevalence by age among either men or women; rather the levels fluctuated by age group. HIV prevalence peaked at 45-49 years among men, while it peaked among women at 30-35 years.

Figure 5: HIV Risk factors

HIV Risk Factors

- Low comprehensive knowledge of HIV (including Knowledge about HIV transmission)
- Low knowledge of HIV status
- Low correct and consistent condom use
- Multiple concurrent sexual partners
- Early sexual initiation and cross generational sex
- Drug and alcohol abuse
- Stigma and discrimination
- High rates of new HIV infections among stable/monogamous relationships (Discordant couples)
- Sexual Violence
- Presence of untreated STIs and STDs
- Late initiation of ART
- TB/HIV co-infection
- Unsafe blood and blood products
- Sharing of sharps and needles

HIV prevalence among pregnant women attending antenatal clinics (ANC) is 3.2% (NACP 2010) and is significantly higher than the national prevalence. The HIV prevalence among pregnant women over the years shows a declining trend from 4.4% to 3.5% between 2007 and 2008, and to 3.2% in 2010, respectively.

While the HIV epidemic is a nationwide concern, there are some notable geographical differences, particularly across the urban-rural divide. HIV prevalence was found to be higher in urban areas (2.7%) than in the rural areas (1.2%), as were levels of knowledge about HIV. The northern district of Koinadugu showed the highest prevalence (3.0%), 6 times higher than the district with lowest prevalence, Tonkolili (0.5%). Pujehun and the Western Urban Area both stand at 2.2%.

Studies conducted between 2007 and 2010 provided information on HIV prevalence among some key populations at risk – sex workers, fisher folks, uniformed personnel, MSM, miners, prison inmates, and cross-border traders. Incidence modelling in the 2010 Modes of Transmission Study revealed that for all new HIV infections in adults (15-49 years), commercial sex workers, their clients and partners of clients contributed 39.7% of new infections. The study also revealed that people in discordant monogamous relationships contributed 15.6% of new infections whereas people reporting multiple partnerships and their partners contributed 40%. Of these, multiple sex partnership groups with the casual heterosexual sex group and their partners contributed about 15%. Fisher folks contributed the second highest incidence (10.8%) followed by traders, transporters and mine workers with 7.6%, 3.5% and 3.2%, respectively. MSMs and IDUs are slowly emerging in the Sierra Leone society. They contributed 2.4% and 1.4% of the new infections respectively.

3.1 Socio-cultural factors affecting the spread of HIV/AIDS among adolescents in Sierra Leone

The complex mix of distinctive spiritual, material and emotional features that make up the culture of a community play a key role in shaping perceptions in that society, including perceptions and behaviours relating to HIV. According to a study published in Medwell Journal, 2011, alcohol and drug abuse, access to pornographic materials, cultism, cosmetic factors, vulnerable sexual practices and blood swearing covenants, are among the factors that fuel the spread of HIV in the society.

The study notes that peer pressure to consume alcohol, especially at social gatherings, has a negative consequence for the fight against the spread of the disease. The reason is that alcohol impairs judgement and often leads to unintended and unprotected sex. In addition, access to pornographic media materials through the prolific community media centres unduly exposes young people to experimental sex on video, thereby increasing their desire to practice unprotected sex with all its negatives consequences at early ages.

The study also reveals that the use of sharps to shed blood as part of initiation rites in some schools' and colleges' social clubs has the potential to contribute to HIV transmission. Unsterilized sharps are also used and shared during rites of passage and to make tribal marks, including black gum, male and female circumcision and the borrowed practice of tattooing. The practice of 'blood swearing covenants' that has become in vogue among gangs of young people and which encourages the shedding and sharing of blood by tying the hands together also exposes the participants to HIV infection.

The practice of 'dry sex', which supposedly tightens the vagina thus increasing the pleasure of the opposite sex, is bound to increase the friction during intercourse, thereby increasing the risk of bruising of skin and the potential of contracting HIV.

For a BCC and advocacy strategy to be effective, it must consider the media landscape and the contextual factors that contribute to it.

3.2 Key Drivers of the HIV Epidemic

Figure 6: Key Drivers of the HIV Epidemic in Sierra Leone

Groups	Adult	Adult & Paediatric
Sex workers and clients	39.7%	3
Casual heterosexual sex	40.8%	3
Mother to Child Transmission (MTCT)	--------	1
Heterosexual sex within union/ regular partnership	15.6%	1
MSM	2.4%	
Injecting Drug Use (IDU)	1.4%	
Health Facility Related	0.1%	
Number of New Infections	5,044	

MoT 2010 study Findings

a. Low Comprehensive Knowledge of HIV (including modes of HIV transmission):

Knowledge about HIV/AIDS preventive education is still very low among the populace (19.7% for women and 31.2% for men aged 15-49 years but higher among young people aged 15-24 years (23.7% and men 32.9%)(DHS 2008). This could be due to their low risk perception. As such there is much effort placed in the areas of behaviour change communication including awareness rising. A BCC strategy was developed in 2004 but has never been revised. Lot BCC interventions including materials such as posters, billboard, T-shirts,, media programmes such as radio jingles and television adverts as well as discussion and face- to- face interactions on various issues such as HCT, condoms, PMTCT and general knowledge about HIV prevention are implemented nationwide. A greater percentage of the BCC materials focused on prevention education while there were very few relating to issues of stigma and discrimination.

While the majority of Sierra Leonean's (women 69.4% and men 82.9%) are aware of HIV and AIDS, just 14% of women and 25% of men have comprehensive knowledge of the issues surrounding it (DHS 2008). A person is said to have comprehensive knowledge on HIV and AIDS if they reject common misperceptions on HIV and AIDS, accurately identify three modes of transmission (i.e. breastfeeding, sexual intercourse, sharing needles, etc.) and if they know a healthy person can have HIV.

There are higher levels of knowledge amongst urban populations compared to rural populations; one in four urban women has comprehensive knowledge compared to one-in-six among rural men. Comprehensive knowledge is higher among urban men (38.8%) and lowest among rural women (7.5%). Young people (15 – 24 years) are somewhat more likely to have a comprehensive knowledge of HIV and AIDS than the population at large (17% of young women and 28% of young men).

There is a pervading public misconception about the modes of HIV transmission in the country. According to the DHS (2008), roughly one in two men and one in three women believe that AIDS can be transmitted by mosquito bites; can be transmitted by supernatural means; and that sharing food with an infected person can cause infection.

The discrepancy between rural and urban areas is noticeable, with almost four out of five rural women and roughly two out of five rural men

holding on to these inaccurate beliefs. A greater proportion of young people are able to reject misconceptions about how HIV is transmitted (about four out of five young men and three out of four young women).

Low comprehensive knowledge of HIV and AIDS, including misconceptions about HIV transmission, has led to high levels of stigma and discrimination towards PLHIV, which in turn makes people reluctant to be tested. It inhibits PLHIV from revealing their HIV positive status, which similarly impedes access to prevention, treatment, care and support. Low knowledge also makes people more likely to engage in high-risk behaviours, such as unprotected sex, multiple concurrent partners or intravenous drug use.

b. Low knowledge about HIV status

Linked to the low level of knowledge about HIV is the low number of people who know their HIV status. In spite of efforts to scale-up HIV counselling and testing in the country and the increase in the number of HCT sites from 19 in 2005 to 543 in 2010, a majority of the Sierra Leoneans do not know their HIV status. Estimates from the Demographic and Health Survey (2008) reveal that only 13% of women and 8% of men aged 15-49 years have ever had an HIV test. Only 9.4% of women and 7% of men have actually received a test result.

In addition, there is a marked difference between rural and urban men and women who know their HIV status (18.8% for urban women, 4.6% rural women, 13.2% for urban men and 3.2% for rural men). The percentage of young people who have tested and know their status is even lower (1.2% of young women and 4.4% of young men). This low percentage of young people (15-24 years) in Sierra Leone who know their HIV status is particularly worrying.

c. Low condom use

Condom promotion is one of the key strategies in response to HIV. However its use continues to be very low (less than 30%) among the population. A National condom programming committee is in place while the national strategic plan for comprehensive condom programming (2010-2014) is in place. There is also no national condom policy in place. Capacities of some service providers have been built on Condom negotiation skills. Number of condoms distributed however increased from 1,968, 646 in 2006 to 3,750,000 in 2009 indicating considerable opportunities exists for condom distribution. Two organizations-CARE and GOAL are engaged in social marketing of condoms while UNFPA also supplies NAS and the Ministry of Health and Sanitation with condoms for free distribution. Female condoms are less popular and not widely used.

The use of condoms consistently during risky sexual encounters is low in Sierra Leone. According to the 2008 DHS, only 19.3% of women and 41.3% of men reported ever used male condoms. Female condom use is extremely low and is estimated at 1.4%. Condom use at last risky sex was lower among the rural population for women (urban – 8.5%, rural-5.3%) and for men (urban-34.4%, rural-10.3%). Condom use is also lower among young people (15-24 years), at 13.8% for females and 22% for males. Very few people report using a condom during their first sexual encounter; just 2.9% of females and 7.3% of males.

The availability and accessibility of condoms is also low. It is estimated that 19% of people source condoms from public health facilities, 4.2% from private health facilities, 26% from pharmacies 0.5% from outreach initiatives and 38% from friends or relatives.

d. Early initiation of sexual relations and cross-generational sex

Women are more likely to have sexual intercourse earlier than men (27.4% of women had their first sexual encounter at 15 years, compared to 7.6% of men) and rural women tend to engage in sexual intercourse the earliest, with the median age at first sex standing at 15.8 years. The median age for first sex for urban and rural men is 18 years. This is despite the fact that the legal age for sexual intercourse is 18 years.

It is not uncommon for young people to engage in cross-generational sex in Sierra Leone. Young women especially, exchange sex for basic needs such as food, accommodation, clothing and other favours. Findings from the DHS (2008) show that over one in ten young women aged 15 -19 years are engaged in sexual relations with male partners aged ten years above their age. In addition, condom use among cross-generational sexual partners is relatively low. HIV prevalence among young women and among older men reflects this trend, with HIV prevalence among women peaking between the ages of 15 – 35 years and among men aged 45 years and above.

Teenage pregnancy and the risk of early contraction of STIs, including HIV stand out as significant implications. Being sexually active at an early age facilitates early marriage, possibly intergenerational. There are also possible complications associated with childbirth including

maternal mortality and morbidity. There is also a possibility of increased chances of high school dropout, with resulting socio-economic inequality and low status of women and girls.

The existing school curriculum has been revised to include topics on HIV/AIDS and Life skills although HIV is not examinable in schools. A number of life skills and HIV/AIDS manuals have been developed and introduced in schools and communities. Some of the teachers have been trained but many still need to be trained. Some of the youths have been trained as peer educators but reaching the out-of-school youths with preventive education remains a challenge.

e. Transactional Sex

Transactional sex involves the exchange of sex for money, favours and gifts. Statistics from the Sierra Leone DHS 2008 study suggests that transactional sex among men is prevalent and stands at 1.9%, with highest among 25-29 years (3.8%). Transactional sex is more prevalent in rural areas (2.2%) compared to urban areas (1.9%), respectively. Results further show that payment for sex is more prevalent among the divorced/widowed/separated (4.4%) compared to the never married (2.3%), and the married or living together (1.8%). Further analysis by education level reveals that men with secondary or higher education (2.3%) are more likely to pay for sex compared to those with primary (2.0%) and no formal education (1.9%), respectively.

Payment for sex by men is exacerbated by low condom use. According to the DHS, 93.6 % of women and 77.9% of men engaged in transactional sex do not use condoms. A society where transactional sex is common increases the vulnerability of young women and clients to HIV and also propels the spread of new HIV infections among the general population.

f. Drug and alcohol abuse

Injecting drug users are an emerging concern for the national HIV response, as their behavioural patterns put them at high risk of HIV transmission. In 2007, 4.8% of drug users surveyed reported an HIV positive status (2007 IDU and non-IDU Report, UNODC) and the Sierra Leone Modes of Transmission Study estimated that IDUs accounted for 1.4% of all new HIV infections in 2008. Almost half (46.7%) reported sharing needles.

g. Commercial Sex Work and Men who have sex with men

Although everyone is at risk of infection with HIV, yet targeting the most at risk populations has been a challenge. While sex workers are periodically targeted others like MSM (Men who have Sex with Men) and IDUs are just are often considered non-existent. It is only now that few of such groups are becoming visible but with much stigma and discrimination. There is also the need to train more service providers to service this group of people.

According to the 2010 MoT study, sex workers and their clients accounts for over a third (35%) of all new HIV infections in Sierra Leone. Prevalence among CSWs is high at 8% and according to the ARC Report of 2007, over one third of CSWs have never used a condom with their clients. One quarter reported having no knowledge of HIV. A study done in 2009 (KAP, CARE) reported that 55% of CSWs indicated that they had never used condoms but would like to in the future.

Men who have Sex with Men (MSM) account for 2% of all new HIV infections. The HIV prevalence rates stands at 7.5%. Condom use is low and STI prevalence stands at 68%.

h. High levels of stigma and discrimination

Stigma and discrimination against PLHIVs is one of the biggest challenges in the HIV response. About 9 in 10 women (94.9%) and about 8 in 10 men (86.6%) have negative attitude towards PLHIVs. This pattern is similar among rural and urban dwellers as well as young people. Accordingly, 51.7% women and 27.2% men state that they would be unwilling to care for PLHIVs when sick. In addition, 79.9% of women and 59.7% of men indicate that they would not buy vegetables from an HIV positive person.

High stigma and discrimination frustrates the implementation of HIV and AIDS prevention, treatment, care and support services, particularly with regards people being discouraged to access these services. This in turn increases the risk of HIV transmission.

i. HIV among discordant couples

Discordant couples are those in which one partner is positive and one is negative. About 1.9% of couples can said to be Discordant, with higher levels in urban areas (U - 2.9% and R - 1.5%). Fidelity or mutual faithfulness among partners in stable and monogamous relationships tends to be protective with regards to transmission of HIV. Despite this, the 2010 Modes of Transmission study shows that over a third of new HIV infections

in Sierra Leone emanate from stable and monogamous sexual relationships.

Low condom use by men and women in this category contributes to a high number of new HIV cases. In addition, to the numerous negative cultural norms surrounding HIV infection, gender inequalities continue to pose serious barriers to women initiating safer sex practices such as condom use

j. Low uptake of PMTCT

Although HIV prevalence among pregnant women continues to decline, there appears to be insufficient knowledge regarding the benefits of PMTCT. Only 14.2% of women and 24.0% of men believe that the use of ARV drugs can reduce the risk of MTCT, and the percentages are much lower in rural areas for women (urban – 23.4%, rural – 8.9%) and for men (urban – 33.6%, rural – 18.0%). Just over one-in-ten women and one-in-five men have knowledge about PMTCT (Breastfeeding and ARV). ART uptake still remains low among pregnant women and just over half, or 511 of health facilities in the country offer PMTCT services.

Effective PMTCT services can reduce HIV infection among new born babies and positive pregnant women on ARV can live longer and healthy lives. Therefore, if coverage and access to PMTCT services are not expanded, babies born to positive pregnant women will be at a risk of contracting HIV. In addition, pregnant positive mothers not accessing a complete course of ARVs or not on ART for their own health have a higher chance of not surviving to an older age.

k. Multiple Sexual Partners

Among both men and women, multiple concurrent sexual partnerships are reportedly high. According the 2008 DHS, 5% of women and 20.8% of men reported having more than two concurrent sexual partners. A similar pattern is observed among urban (women 6.1% vs men 21.3%) and rural dwellers (women 4.3% vs men 20.4%). The pattern is similar among young people 15-24 years.

Furthermore, fewer women (7.4%) than men (22.1%) used a condom at their last risky sexual encounter. Similarly, among young people 15-24years, 14% of women and 22% of men used condoms at their last risky sexual encounter. On the overall, more men than women tend to engage in multiple and risky sexual partnerships.

By implication, these findings suggest that without reducing the number of partners and an increase in condom use during risky sexual behaviour, HIV will continue to spread.

l. Sexually Transmitted Infections

Sexually transmitted infections (STI) are highly prevalent among the population. Hence management of STIs is a core component of the prevention of HIV. Protocol for Syndromeic management of STIs was developed and disseminated. PHU staff were also trained on STI management. There was also implementation of routine STI surveillance. Little or no evidence of effective SRH/HIV as well as HIV/AIDS and STI integration exists.

The occurrence of Sexually Transmitted Infections (STI) including HIV is below one in ten among the sexually active population (15-49 yrs), with a marginal difference between women and men (8.5 and 8.3% respectively). However, the presence of genital sores and ulcers are more common in women than in men (19.3 and 11.4% respectively) and those are higher in urban than rural both in women (urban - 12.7% and 10.6%) and men (urban - 24% and rural- 16.3%).

The percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services is higher among men than women (51% and 41% respectively). In terms of knowledge about STI prevention, men have more knowledge than women at all age groups, and among women 15-24 yrs age group has more knowledge than 15-49 yrs group (23.7% in women and 32.9 in men between age 15-25 yrs, and 19.7% in women and 31.2% in men between 15-49 yrs, 2008 SDHS).

In terms of Men having Sex with Men (MSM), one of the most-at-risk populations, the 2010 study showed an STI prevalence of 10.2%, which is higher than general public. Condom use among MSM was reported at 8.2%, thereby leaving over 90% of them exposed to the risk of contracting STIs including HIV.

According to the 2008 DHS, there is no difference in the prevalence of HIV among women with STIs and those without; however, HIV prevalence is higher among those who did not know whether they had an STI (2.4 %) than those who knew their STI status. STI and HIV co-infection in general is 1.5% (1.6% in women and 1.1% in men, respectively). Men who reported having an STI or STI symptoms were slightly less likely to be HIV positive than those who did not report having an STI, although the difference is small (1.1 and 1.5 %, respectively). Currently close to 1,800 health care workers and other service

providers are trained in STI treatment and the number is increasing as part of priority intervention of National Strategic Plan on HIV.

m. Integration of Sexual and Reproductive Health Services:

The duplication of some services and gaps in other services exists due to lack of integration of sexual and reproductive health (SRH) services. Programmes are sometimes set up which could be more efficiently managed by existing institutions. The number of health facilities with integrated SRH and HIV services is still limited. The procurement of drugs by different institutions targeting the same beneficiaries leads to wastage of scarce resources. Monitoring and supervision of ongoing implementation is hindered due to the lack of integration of services.

n. Late initiation of Anti-Retroviral Therapy:

The timely initiation of antiretroviral therapy (ART) is critical in HIV prevention because a dramatically lowered viral load suppresses the onward transmission of HIV to other people when adherence levels are high. Sierra Leone's ART guidelines, which were aligned to international guidelines in 2007, have adjusted eligibility from a CD4 count of 200 to 350. As such, people could begin treatment before they became ill and more infectious. However, as per the 2010 Joint Programme Review of the National HIV and AIDS Strategic Plan 2006-2010, although ART treatment services has been dramatically scaled up, only 52 % of eligible adults and 5 % of eligible children were receiving ART by 2010, and adherence and delivery continue to pose grave challenges in Sierra Leone.

In fact, the number of ART sites of 132 is far below those of the HCT sites of 556. Most people tested and received positive status in HCT sites are often referred to ART facilities for treatment. Therefore many are presented late to the ART facilities and delay in initiating ART. Currently about 6,000 patients are on ART and 88% of those survive after 12 months. Only 64% of the identified women infected with HIV receive ART for PMTCT which is far below the national target of 90%.

o. HIV/TB Co-infection:

Tuberculosis (TB) is the most common opportunistic infection among PLHIVs and the number one cause of death in HIV patients. HIV infection predisposes to TB re-activation or new infection, and TB/HIV co-infection increase morbidity and mortality, multi-drug resistant of TB cases, drug interactions, and increased drug adverse reactions.

In Sierra Leone, the HIV/TB co-infection rate is estimated to be high, but the level of screening for co-infection is low; only 23% of all HIV positive patients have been screened for TB.

According to the health facility based study in 2009, 14.4% of the HIV patients were found to have pulmonary TB with the highest occurrence found in patients over age 50yrs, between 11-20yrs and 31- 40yrs (54.17%, 18.75% and 15.22% respectively). TB/HIV co-infection was also found to be three times higher among men (20.7%) than women (7.3%)

p. Blood Safety and Universal Safety Precaution:

The medical needs for blood is increasingly becoming higher especially the advent of the Free Healthcare initiative launched in 2010. Blood and blood products however can be a source of HIV transmission if not safely screened for HIV, syphilis and hepatitis. Although only a small number of infections occur as a result of medical injections and blood transfusions (0.2%), there are reasons for concern of medical transmission of HIV.

In Sierra Leone there are only five operational blood banks in the whole country (3 in the Western area and 1 each in Bo and Kenema). The lack of sufficient blood banks means that people have to go a long way to get safe blood and this might lead to a compromise of normal procedure. The number of voluntary blood donors is also still low and concentrated in the urban areas.

The biomedical transmission of HIV can be reduced through enhancing of the universal safety precautions, increase in availability of PEP services in health facilities, prompt administration of PEP to HIV exposed health workers and those who need it and screening of all donated blood for HIV and other Transfusion Transmittable Infections (TTIs) such as hepatitis.

Sierra Leone is in the process of rolling out facility based blood safety programme, which are critical for reducing the risk of medical transmission of HIV. National Safe Blood Programme at Ministry of Health and Sanitation indicates that all blood meant for transfusion should be screened for Hepatitis, Syphilis and HIV. As a result all bloods for transfusion are currently screened at 24 blood-screening sites.

There is lack of comprehensive information on injecting drug use in Sierra Leone. However,

according to UNODC study, there are about 14% of drug user are IDUs in Freetown, and nearly half (47%) of them share needles and syringes. In addition, 1.6% of sex workers are injecting drug users and 87% of them share needles and syringes.

q. Resource Mobilization for HIV:

Soon after the end of the debilitating war, Sierra Leone took a bold step of combating the new war against HIV. GoSL took up a loan of US$ 15 million (2004-2008 period) with the World Bank for the Sierra Leone HIV and AIDS Response Project, (SHARP). GoSL also successfully applied for funding from the Global Fund rounds 4, 6 and 9 for US$ 18 million, US$ 26 and US$ 29 million respectively.

Over the years the national response to the HIV/AIDS has received substantial funding, however the major challenge now is how to sustain the financial support for the fight against HIV epidemic.

In fact according to the National AIDS Spending assessment (NASA 2010) there is low financial consideration from GoSL and Private sector (2.7% and 0.7% respectively) and 95% of HIV budget is depended on Global Fund.

The scarcity of national funds has limited the expansion and sustainability of HIV programmes thus increasing vulnerability of Sierra Leoneans to the epidemic. Moreover such a heavy reliance on the Global Fund and indeed on international donors generally leaves HIV programmes vulnerable to collapse as a result of donor fatigue or change in donor priorities.

r. Sexual and Gender-Based Violence:

Gender dynamics can exacerbate HIV risk, for example, certain manifestations of male and female norms, behaviours and practices create vulnerability to HIV infection. Equitable access to HIV prevention services and activities needs to be ensured, and female-controlled access to income generation and livelihood strategies should be implemented where possible. There are cultural and legal underpinnings to gender discrimination and HIV risk, with legal rulings not aligned to legislation or widespread beliefs and practices around husbands' roles in decision-making, including health care. Specifically sexual and gender-based violence directly increases the risk of HIV infection. Sierra Leone suffers from high levels of sexual violence and it also poses threats to HIV prevention. Sexual violence can take many forms, including rape, child molestation and wife battering.

More women than men (over a third compared to a quarter) believe that a women is not justified in refusing sex to her husband, implying that many women themselves are complicit in such acts. Child molestation by elderly family members and rape are often extremely disempowering situations, with the survivor having little chance of negotiating safe sex.

Apart from the obvious psychological and physiological damage, sexual violence increases the risk of HIV transmission, particularly because one of the partners is not in a position to initiate condom use. Lack of economic empowerment and higher levels of poverty among women leads women to exchange sex for money or favours, thus exposing them to HIV.

The Family Support Unit (FSU) was established in 2000 as a branch of Criminal Investigations Department (CID) to deal with all forms of abuses against women and children including SGBV.

The number of facilities that provide assistance to survivors of gender based violence and sexual abuse free of cost has increased, with four government hospitals providing SGBV assistance in 2010. SGBV services were mainly provided by NGOs (Women in Crisis Management, International Rescue Committee etc.) previously.

Rights based and gender responsive policies, programmes and legislations have been developed and implemented and contributed to support SGBV cases. As of 2011, three Gender Acts, The Devolution of Estates Act, The Domestic Violence Act, and The Registration of Customary Marriage and Divorce Act are enacted.

s. Divine Healing of HIV:

Within some strands of both of Sierra Leone's two main religions (Islam and Christianity), belief in divine healing is promoted as opposed to western medical interventions, i.e. ART. Some leaders have publicly pronounced to have prayed for HIV infected persons who have become HIV free but this is not consistently followed up with medical examination.

Failure to initiate or continue ART due to the belief they have been healed can ultimately result in increased AIDS-related deaths. People who believe that they have been healed are less likely to practice safe sex that leads to increased risk of contracting STIs including HIV.

In regard to mitigation of religious and cultural norms, Sierra Leone is in the process of expanding

dialogue with religious leaders. Inter religious organizations have been formed and are addressing stigma and discrimination issues around HIV through education sessions during the religious services.

3.3 Media Landscape

Part of understanding the context in which the BCC and Advocacy Strategy will operate is understanding the "media landscape" in Sierra Leone; the what, where, who, why and how of national media usage.

a. Language

Mende is the most common mother tongue in Sierra Leone (36%), followed by Temne (25%) and Limba (10%). However, the language most people say they speak well is Krio (78%), followed by Mende (41%), Temne (35%) and English (18%). English is by far the most common language people can read (22%), with a very small minority reading Krio (4%), Mende and Temne (both less than 3%). Over half listeners are identified as 'never been to school' (illiterate).

According to the DHS (2008), while the majority of Sierra Leonean's (women 69.4%, men 82.9%) are aware of HIV and AIDS, just 14% of women and 25% of men have a comprehensive knowledge of the issues surrounding it. A person is said to have comprehensive knowledge on HIV and AIDS if they reject common misperceptions on HIV and AIDS, accurately identify three modes of transmission (i.e. breastfeeding, sexual intercourse, sharing needles, etc) and if they know a healthy person can have HIV.

b. Sources of information

According to the survey on media use, conducted by Foundation Hirondelle in 2010, radio is the most used source (78%) of media information on current affairs for Sierra Leoneans, followed by mobile phones (18%) TV (8%). Interpersonal communication was also cited as an important and reliable source of information. Radio is also seen as the most reliable source of information (68% of respondents), compared to information from friends and relatives and religious or community leaders (all less than 6%). The survey reveals that 86% of men and 78% of women listen to the radio. Most of those surveyed say they listen to radio at home.

c. Radio

82% of people listen to the radio, with Moyamba and Pujehun having the highest radio audience (both over 95%). There is little difference between rural and urban areas, between men and women or between age groups.

d. Newspapers

About 9% of respondents said they read a newspaper, but only 1% does so regularly. The three most-read papers are the Concord Times, Awoko and Awareness Times. Readership is highest in Freetown where one in five persons claim to read the newspaper. More men than women are readers.

e. Television

One in four say they ever watch TV, an increase from one in seven in 2008. The most popular places to watch TV are the home and viewing centres, followed by at friends or neighbours. Apart from Freetown where one third watch TV, viewing is very low (less than one in ten, apart from Kono, at one in seven). SLBC is watched by the most people (over 60%), however the most frequently watched channels are Super Sports, ABC and Africa Magic.

Internet

Internet usage was low, at 3.4%; in 2008 the figure was the same, indicating that Internet usage is not growing. Unsurprisingly, Internet usage is highest in Freetown and urban areas. Most (over two thirds) access the Internet at Internet cafes. The most common usage is for checking Email (two thirds), General Information (one in five) and sport information (one in ten). There is a strong educational bias, with those with a tertiary degree most likely to have used the Internet

f. Media Access

The survey reveals startling statistics on media access at home. According to the survey, a little over 75% of respondents said they had access to radio, and 72% of those ran on battery. Many respondents, however, pointed out that they face some difficulties listening to radio. The biggest problem identified is the cost and availability of batteries, which nearly everyone relies on as few have access to electricity supply. About 25% of respondents noted that they were too poor to afford a radio set.

g. Radio Listening

Krio is by far the most listened to language on the radio (two out of three people). Other common languages include Mende (one in two), Temne (one in three) and English (one in four). The most popular types of programme

listened to are news and news-related programmes (68%). Agriculture, health, political matters and music are also popular.

About 50 radio stations operate in Sierra Leone. The number of radio stations by Province is listed as follows:

National radio stations – 2

Western Area – 26

Southern Area – 6

Northern Area – 10

Eastern Area - 5

h. BCC Materials

Posters, Billboards, brochures, and other materials have been used to communicate HIV messages. The following is a summary inventory of the HIV messages used:

Figure 3: Summary of BCC materials

	Theme of Message	Number of messages
1.	HIV testing (excluding PMTCT)	5
2.	Condom promotion	4
3.	Other prevention methods	7
4.	PMTCT	5
5.	Impact of HIV and AIDS	2
6.	Workplace	3
7.	Anti-retroviral therapy (excluding PMTCT)	3
8.	Stigma & Discrimination	1
9.	Living positively	1

There are 2 billboard messages, 28 poster messages, 8 brochure messages, 4 sticker messages, 2 file folder messages and 1 hand bill message.

Interviews with HIV and AIDS service providers during the development of this BCC and Advocacy strategy revealed that most providers focus predominantly on mass media for their public and community outreach on HIV/AIDS education. This has not yielded the desired effects due to the high levels of illiteracy in society and poverty; which limits access to newspapers, radio and television, which have been the centerpiece of the mass media approach.

3.4 SWOT analysis of BCC Environment in Sierra Leone

a) Strengths

There is strong political commitment on the part of Government to the fight against HIV/AIDS in the country. The President is the Chairman of the National AIDS Council (NAC). The National AIDS Secretariat (NAS) was recently transformed to a Commission by an Act of Parliament, with increased powers to operate on issues dealing with HIV/AIDS and with direct budgetary allocation from Government. There is also a growing IEC/BCC culture among partners in the fight against the disease. There are IEC/BCC units at the NAS, World Health Organisation (WHO) and partner NGOs, dedicated to HIV/AIDS prevention, treatment and management.

In addition, the is a dedicated National Communications structure located within the Ministry of Health and Sanitation (MOHS) within the Health Education department that has exhibited commitment to the fight against HIV/AIDS. The decentralisation system that has seen the devolution of essential functions (health, education etc.) from the national to the local councils has also helped in the fight against the disease.

b) Weakness

Key among the weaknesses of the BCC and advocacy intervention in the country is the lack of standardisation and harmonisation of BCC materials. Implementing partners have standalone strategies and they develop their own messages without central coordination. The result has often been contradictions and controversies around the messaging. The NAS itself does not have a viable IEC/BCC unit and has not had a comprehensive BCC strategy until now. Also, the BCC structures and linkages are weak and are overly dependent on the use of the mass media for information dissemination.

c) Opportunities

The continued support of donor partners for BCC in the country and the establishment of BCC institutions in the country bode well for the development of BCC and advocacy interventions in the fight against HIV/AIDS. The broadening media landscape in the country also presents an opportunity for improvement in BCC activities in the country. The improving policy environment and data availability are all opportunities for BCC intervention in the fight against the disease. Finally, this BCC and Advocacy Strategy 2011-2015 should enhance coherence, relevance and resource mobilisation.

d) Threats

The fact that an overwhelming percentage of HIV/AIDS funding still comes from donor partners is a looming threat to progress made in this direction. With the current global financial crisis in donor countries, there is a present risk that where fatigue may set in, and where the country may not have the funds to support the programme, it may lead to abandonment of some activities.

Taboos surrounding the discussion of sex and sexuality, especially between young people and adults threaten the flow of information on such matters in the home.

4.0 Behaviour Change Communication Framework

The tables below display the key drivers of the HIV epidemic and aim to provide a framework for analysing each issue and responding in a targeted manner. Each table names and describes a key driving factor in the epidemic, explains the contextual factors influencing the problem behaviour and the implications of the behaviour with regards HIV, and lists the desired behavioural change objectives, communication objectives, the target populations/audiences, and the means or channels of communication.

Table 1: Knowledge about HIV and AIDS

KNOWLEDGE ABOUT HIV AND AIDS		
1	**Problem statement**	While the majority of Sierra Leonean's (women 69.4%, men 82.9%) are aware of HIV and AIDS, just 14% of women and 25% of men have a comprehensive knowledge of the issues surrounding it (DHS 2008). A person is said to have comprehensive knowledge on HIV and AIDS if they reject common misperceptions on HIV and AIDS (list the main common misconceptions), accurately identify three modes of transmission (i.e. breastfeeding, sexual intercourse, sharing needles, etc) and if they know a healthy person can have HIV.
2	**Factors influencing behaviour**	At 1.5%, HIV prevalence is relatively low in Sierra Leone compared to many countries in southern and eastern Africa. Accordingly, public information campaigns and distribution of IEC materials have been less aggressive also. Negative cultural norms and beliefs, including the low status of women and girls also contributes to the low level of knowledge about HIV and AIDS. Linked to this, low literacy levels, especially in rural areas and amongst women (nine out of ten rural women and more than two thirds of rural men are illiterate) and the fact that over half of women and over one third of men are not exposed to any media, present challenges for communicating HIV messages effectively.
3	**Implications**	Low comprehensive knowledge of HIV and AIDS has led to high levels of stigma and discrimination towards PLHIV, which in turn makes people reluctant to be tested. It inhibits PLHIV from revealing their HIV positive status that similarly impedes access to treatment and support. Low knowledge also makes people more likely to engage in high-risk behaviours, such as unprotected sex or intravenous drug use.
4	**Behavioural objectives**	• To increase the number of people with accurate knowledge about HIV/AIDS issues • To increase the number of people with high personal risk perception regarding HIV • To increase the number of people who know how and where to access HIV services
5	**Communication objectives**	• To provide accurate information about the modes of HIV transmission • To dispel myths and misperceptions about HIV and AIDS • To promote availability and access to HIV services/Centers
6	**Target audiences**	• **Primary Audience:** Adults, Adolescents, young people (15-24) and in-school and out-of-school youths, MARPS • **Secondary Audience:** Peer educators/animators, outreach workers, Traditional/religious leaders, political leaders, teachers, health care workers
7	**Proposed key messages**	• The only way to know your HIV status is by an HIV test • HIV is transmitted through bodily fluids i.e. during unprotected sex, pregnancy, intravenous drug use, re-use of sharps. • HIV is not transmitted through mosquitoes bites or casual contact
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups (using public lectures, street theatre, community animation, story-telling, song and dance, etc) • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 2: Knowledge of HIV Status

KNOWLEDGE OF HIV STATUS		
1	Problem statement	In spite of efforts to scale-up HIV Counseling and Testing in the country and the increase in the number of HCT sites from 19 in 2005 to 543 in 2010, a majority of the Sierra Leoneans do not know their HIV status. Estimates from the Demographic and Health Survey (2008) reveal that only 13% of women and 8% of men aged 15-49 years have ever had an HIV test. Only 9.4% of women and 7% of men have actually received a test result with a marked difference between rural and urban populations (19% for urban women, 4% rural women, 13% for urban men and 3% for rural men).
2	Factors influencing behaviour	Many people are afraid of getting a positive result as it is perceived as a death sentence. Low risk perception, stigma and discrimination around going for a test and towards PLHIV also contribute negatively. Limited HCT services, low awareness about and limited accessibility to these services, and insufficient awareness campaigns also contribute to people not doing the test voluntarily and knowing their results. Negative cultural norms and beliefs among the population on HIV, including myths and misconceptions on testing and knowing results add to the challenge.
3	Implications	The low number of people who know their status leads to a low number of PLHIV who receive ART. This increases the risk of HIV transmission to other people.
4	Behavioural objectives	• To increase number of people who know their HIV status • To increase the number of people with high risk perception of HIV • To reduce the number of people with negative myths and beliefs about HIV
5	Communication objectives	• To promote the benefits of knowing your HIV status • To dispel myths and negative perceptions about HIV • To promote the availability and accessibility of HCT services/centers
6	Target audiences	• **Primary Audience**: Adults, Young people (15-24), in-school and out-of-school youths, MARPS, pregnant women • **Secondary Audience**: Peer educators/animators, outreach workers, Traditional/religious leaders, teachers, health care workers
7	Proposed key messages	• It is important to know your HIV status • The only way to know your HIV status is by an HIV test • The HIV test is free, confidential and available at all heath care facilities • Knowing the HIV status of your partner can help you to stay negative
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 3: Knowledge of HIV Transmission

KNOWLEDGE OF HIV TRANSMISSION		
1	**Problem statement**	There is a pervading public misconception about the modes of HIV transmission in the country. According to the DHS (2008), over 60% of women and 50% of men believe that HIV can be transmitted by mosquito bites. In addition, over 50% of both men and women believe that HIV can be transmitted by supernatural means, and over 60% of women and 50% of men believe that sharing or buying food from an HIV infected person can cause infection.
2	**Factors influencing behaviour**	Low literacy levels and limited access to media have contributed to the ineffectiveness of IEC interventions to date, as well as the low level of dissemination of such materials. Negative cultural norms and beliefs, and the tabooing of discussion of sexual issues, especially between adults and young people, have also contributed to the problem.
3	**Implications**	As long as the misconceptions remain about how HIV is transmitted, PLHIV will continue to suffer from stigma and discrimination. High levels of high-risk behaviour emanating from the trivialization of HIV issues continue to be a problem.
4	**Behavioural objectives**	• To decrease the number of people with negative myths and misconceptions about HIV • To increase the number of people with accurate information about the modes of HIV transmission • To increase the number of people with accepting attitudes about PLHIVs
5	**Communication objectives**	• To dispel negative myths and misconceptions about HIV transmission • To provide correct information about modes of HIV transmission • To discourage stigma and discrimination towards PLHIVs
6	**Target audiences**	**Primary Audience**: Adults, Young people (15-24), in-school and out-of-school youths, MARPS, Traditional/religious leaders, pregnant women **Secondary Audience:** Peer educators/animators, outreach workers, teachers, health care workers, policy makers
7	**Proposed key messages**	• Healthy looking persons can have HIV • Mosquito bites cannot transmit HIV • AIDS cannot be transmitted by supernatural means • A person cannot contract HIV by sharing food with infected persons • To get free accurate information on HIV/AIDS, contact the nearest health service center
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers, murals) and electronic (internet, community, private and government radio, jingles, documentaries and TV) media.

Table 4: Stigma and Discrimination

HIGH STIGMA AND DISCRIMINATION		
1	**Problem statement**	Stigma and discrimination against PLHIVs is one of the biggest challenges for HIV and AIDS prevention. More than 9 in 10 women and about 8 in 10 men have negative attitude towards PLHIVs. This pattern is similar among rural and urban dwellers as well as young people. Further, half of all women and more than a quarter of all men state that they are unwilling to care for PLHIVs when sick. In addition, Four out of five women and three out of five men indicate that they would not buy food items from an HIV positive person. About half of all women and men expressed negative attitudes towards PLHIVs, saying that they should not be allowed to work in public or private establishments.
2	**Factors influencing behaviour**	Low level of knowledge regarding the modes of HIV transmission and pervading myths and misconception surrounding HIV issues are important factors. There is limited sensitization on stigma and discrimination.
3	**Implications**	The implementation and uptake of prevention, treatment, care and support services are hindered. This in turn heightens the risk of increased HIV infections.
4	**Behavioural objectives**	• To increase the number of people with accepting attitudes towards PLHIVs • To increase the number of people who reject negative myths and misconceptions about modes of HIV transmission • To increase the number of people with comprehensive knowledge about HIV and AIDS • To increase number of PLHIV meaningfully involved in combating stigma and discrimination
5	**Communication objectives**	• To inform and educate people on the modes of HIV transmission. • To dispel negative myths and misconceptions about HIV and AIDS • To promote the image of PLHIVs as valued members of society
6	**Target audiences**	**Primary Audience**: Adults, Young people (15-24), In-school and out-of-school youths, MARPS, pregnant women **Secondary Audience**: Peer educators/animators, outreach workers, Traditional/religious leaders, teachers, health care workers, policy makers and political leaders
7	**Proposed key messages**	• A person cannot contract HIV by sharing food with infected persons • PLHIVs should have their human rights respected • HIV positive people deserve care • Test to know your HIV status, and to stay healthy • Preventing HIV starts with knowing your status
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) \ • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 5: Condom Use

LOW CONDOM USE		
1	**Problem statement**	The use of condoms during risky sexual behaviour is low in Sierra Leone. Only 1 in 5 women and 2 in 5 men report using male condoms. Female condom use is lower still and is estimated at 1.4% (Males: 0% and females: 1.4%). Condom use at last risky sex was lower among the rural population for women (U –8.5%, R-5.3%) and for men (U-34.4%, R-10.3%). Condom use is also lower among young people (15-24 years), at 13.8% for females and 22% for males. Very few people report using a condom during their first sexual encounter; just 2.9% of females and 7.3% of males. The availability and accessibility of condoms is also low. It is estimated that most people source condoms from friends or relatives (38%), 19% of people source condoms from public health facilities, 4.2% from private health facilities, 26% from pharmacies and 0.5% from outreach initiatives.
2	**Factors influencing behaviour**	Significant stigma still surrounds condom use; due to some religious beliefs that prohibit their use and cultural misperceptions that condom use implies or encourages infidelity. There is limited information flow on condoms especially among the rural communities. Condoms are not always easily accessible, as many popular retail outlets refuse to sell them and access to free condoms is limited. Social norms may inhibit women and girls from promoting condom use with their sexual partners.
3	**Implications**	Low condom use results in higher levels of STI's including HIV. Higher rates of unwanted pregnancies and teenage pregnancies also correspond with low condom use.
4	**Behavioural objectives**	• To increase the number of people with knowledge of the dual protective value of condom (STIs/HIV and unwanted pregnancy) • To increase the number of people with knowledge of the availability and accessibility of condoms • To increase the number of people using condoms correctly and consistently • To increase number of women who negotiate safer sex
5	**Communication objectives**	• To promote the dual protective value of condoms • To dispel myths and misconceptions about condom use • To increase risk perceptions of STIs/HIV and unwanted pregnancy • To promote women (and men's) right to safe sex
6	**Target audiences**	**Primary Audience**: Adults, Young people (15-24), in-school and out-of-school youths, MARPS, PLHIV **Secondary Audience**: Peer educators/animators, outreach workers, Traditional/religious leaders, teachers, Health care workers
7	**Proposed key messages**	• Correct and consistent condom use prevents STIs/HIV and unwanted pregnancy • Avoid STI/HIV, use condoms • Correctly fitted condoms do not diminish the sexual encounter
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 6: HIV Among Stable Monogamous Relationships

HIV AMONG STABLE MONOGAMOUS RELATIONSHIPS		
1	**Problem statement**	The HIV prevalence stands at 1.4% among women and 1.3% among men in stable and monogamous relationships; however among Discordant Couples (where one partner is positive and one is negative) the prevalence is 1.9% (Urban 2.9% and Rural 1.5%). Fidelity or mutual faithfulness among partners in stable and monogamous relationships tends to be protective with regards to transmission of HIV. However, the 2010 Modes of Transmission study shows that over a third of new HIV infections in Sierra Leone emanated from stable and monogamous sexual relationships.
2	**Factors influencing behaviour**	Low condom use by men and women in this category contributes to a high number of new HIV cases. In addition to the numerous negative cultural norms surrounding HIV infection, gender inequalities continue to pose serious barriers to women initiating safer sex practices such as condom use. Also, unfaithfulness among partners amidst unprotected sex, contributes greatly to the incidence of HIV
3	**Implications**	Due to the low level of condom use, there is a high risk of increased new HIV infections among monogamous discordant couples. Being HIV positive can lead to higher family expenditure on health, it places a burden on the family finances and social stability. The infidelity of a partner can cause them to suspect the other partner and continue to create mistrust within the relationship.
4	**Behavioural objectives**	• To increase the number of couples who know their HIV status • To increase the number of couples who practice mutual fidelity • To increase the number of couples who use condoms correctly and consistently • To increase the number of PLHIV in a discordant relationship who are on ART
5	**Communication objectives**	• To promote couple counselling and testing for HIV • To promote correct and consistent use of condoms • To promote mutual fidelity
6	**Target audiences**	**Primary Audiences**: Married couples and couples in steady relationship, adults (men and women) **Secondary Audiences**: PLHIV, match makers, traditional and religious leaders, Peer educators/animators, outreach workers
7	**Proposed key messages**	• Faithfulness to one faithful sexual partner reduces the risk of HIV transmission • Practicing safer sex will reduce HIV transmission • Knowing your HIV status early enough can prevent infecting a partner and loved one
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV), traditional and folk media.

Table 7: Knowledge and Uptake of PMTCT

KNOWLEDGE AND UPTAKE OF PMTCT		
1	Problem statement	Although HIV prevalence among pregnant women continues to decline, there appears to be insufficient knowledge regarding the benefits of PMTCT. A quarter of women and half of all men believe that HIV can be transmitted through breastfeeding. Only 14.2% of women and 24.0% of men believe that the use of ARV drugs can reduce the risk of MTCT, and 12.6% of women and 19.8% of men have knowledge about PMTCT (Breastfeeding and ARV). ART uptake still remains low among pregnant women and just over half of health facilities in the country offer PMTCT services.
2	Factors influencing behaviour	There are a number of factors that continue to influence low knowledge about and uptake of PMTCT services among pregnant women. These relate to high levels of stigma and discrimination in the community, limited distribution of IEC material on PMTCT, low male involvement and fear of reprisal from partners. In addition, only about half of the health facilities offer PMTCT services across the country. In addition, there is low level of knowledge about the disease and the lack of review and implementation of policy guidelines that exacerbates un guided risky behaviours.
3	Implications	Effective PMTCT services can reduce HIV infection among newborn babies and positive pregnant women on ARV can live longer and healthier lives. Therefore, if coverage and access to PMTCT services are not expanded, babies born to positive pregnant women will be at a risk of contracting HIV. In addition, pregnant positive mothers not accessing complete course of ARVs or not on ART for their own health have a higher chance of not surviving to an older age.
4	Behavioural objectives	• To Increase the number pregnant women who enrol into PMTCT programme • To increase the number of HIV pregnant women on complete course of PMTCT • To increase the number of pregnant women on complete course of ARVs
5	Communication objectives	• To promote male involvement in PMTCT • To promote couple counselling • To raise awareness about the benefits of PMTCT services • To promote correct information about the mode of HIV transmission during pregnancy, labour and breastfeeding • To promote ARV adherence among HIV pregnant women and their children
6	Target audiences	**Primary Audiences**: Pregnant women, women of child bearing age, young adults, male partners of pregnant women **Secondary Audiences:** Sexually active men and Health care workers, religious and traditional leaders, TBAs and policy makers
7	Proposed key messages	• HIV prevention should involve the mother and the father • Testing for HIV early during pregnancy can helps ensure a healthy baby • ARVs help prevent HIV transmission from mother to child • Early uptake of ANC services early during pregnancy helps ensure a healthy baby
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV), folk and traditional media

Table 8: Early Sexual Activity

EARLY SEXUAL ACTIVITY		
1	Problem statement	Almost 60% of young people (15-24 years) in Sierra Leone are sexually active. Women are more likely to have sexual intercourse earlier than men (27.4% of 15 year old women compared to 7.6% of men) and rural women tend to engage in sexual intercourse the earliest, with the median age at first sex standing at 15.8 years. The median age for first sex for urban and rural men is 18 years. This is despite the fact that the legal age for sexual intercourse in 18 years.
2	Factors influencing behaviour	Low literacy levels, especially amongst girls, are a major factor**.** Negative cultural norms and beliefs i.e. (girls only have a place in the kitchen and should be married early) and the low status of women and girls generally, is a driving force behind early marriage and early sexual initiation in the communities. Female Genital Cutting which is practiced almost universally and in the majority of cases is done before the age of 18 is correlated with earlier sexual initiation (UNFPA). Other factors include negative peer pressure experienced by youths, poverty**,** and limited information on sexual reproductive health, HIV and family life education. Today's youths have access to negative media material including pornographic material, although it should be noted that general access to media is relatively low, with over one third of men and over half of women not having access to any media**.** Sexual Gender Based Violence such as rape is a common and Influences early influencing activities.
3	Implications	Teenage pregnancy and risk of early contraction of STIs, including HIV stand out as significant implications which need to be considered. Being sexually active at an early age facilitates early marriage, possibly intergenerational. There are also complications with childbirth including maternal mortality and morbidity. There is increased chance of high school dropout, with resulting socio-economic inequality
4	Behavioural objectives	• To increase the number of young people delaying sexual debut • To reduce the number of girls who are given into early marriage • To reduce the number of youth who have access to pornographic materials • To increase the number of young people participating in life skills education
5	Communication objectives	• To promote the benefits of delaying sexual debut • To dispel negative cultural norms and beliefs • To promote the benefits of SRH/ life skills education among young people • To promote the benefits of girl child education
6	Target audiences	**Primary Audience:** Parents, Young people (15-24) and in-school and out-of-school youths, MARPS **Secondary Audience:** Peer educators/animators, outreach workers, Traditional/religious leaders, teachers, health care workers, teachers
7	Proposed key messages	• Early sexual intercourse can disempower women • Early unprotected sex can increase the risk of HIV infection • Parenthood is for adults • Waiting until 18 is cool • Education is better than early sexual initiation
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 9: Transactional Sex

TRANSACTIONAL SEX		
1	**Problem statement**	Transactional sex involves the exchange of sex for money, favours and gifts. Statistics from the Sierra Leone DHS 2008 study show that transactional sex among men stands at 1.9%, with highest among 25-29 years-3.8%. Transactional sex is more prevalent in rural areas (2.2%) compared to urban areas (1.9%), respectively. Results further show that payment for sex is more prevalent among the divorced/widowed/separated (4.4%) compared to the never married (2.3%) and the married or living together (1.8%). Further analysis by education level, reveals that men with secondary/ higher education (2.3%) are more likely to pay for sex compared to those with primary (2.0%) and no formal education (1.9%), respectively. Payment for sex by men is exacerbated by low condom use. 93.6 % of women and 77.9% of men did not use condom during last risky sex.
2	**Factors influencing behaviour**	Some of the factors influencing the high levels of transactional sex in Sierra Leone include the low socio economic status of women, gender inequalities, low risk perceptions among men and women of contracting STIs, and societal norms which tolerate men having multiple non-regular sexual partners. Drug and alcohol abuse is also considered to be another factor exacerbating this high-risk sexual behaviour.
3	**Implications**	A society where transactional sex is common increases the vulnerability of young women and clients are increased and also propel the spread of new HIV infection among the general population.
4	**Behavioural objectives**	• To reduce the number of women and girls engaged in transactional sex • To increase the number of women and girls who correctly and consistently use condoms • To increase the risk perception among women and girls who engage in transactional sex
5	**Communication objectives**	• To inform and educate women and girls of the risks of engaging in transactional sex • To promote correct and consistent use of condoms among young women and girls • To discourage transactional sex
6	**Target audiences**	• **Primary audience**: Economically disadvantaged women, young people (15-24), Teachers/ lecturers, Workplace officials, in-school and out-of-school youths, MARPS • **Secondary Audience**: Outreach workers, Religious and traditional leaders
7	**Proposed key messages**	• Avoid STI/HIV, use condoms • Correctly fitted condoms do not diminish the sexual encounter • Do not give your body for favours • She is young enough to be your daughter • He is old enough to be grand pa • Behind that bomber phone is an STI • Don't risk it. Keep to your partner
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Group events • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 10: Cross-generational Sex

CROSS-GENERATIONAL SEX		
1	Problem statement	Cross generational is pervasive in Sierra Leone. Young women exchange sex for basic needs such as food, accommodation, clothing and other favours. Findings from the DHS (2008) show that over one in ten young women aged 15 -19 years are engaged in sexual relations with male partners aged ten years above their age. In addition, condom use among young people and male adults engaged in risky sexual behaviour is relatively low. As a result, HIV prevalence among young women and among older men is higher as shown by the DHS. HIV prevalence among women peaked between the ages of 15 – 35 years and among men in the age group 45 years and above.
2	Factors influencing behaviour	Factors contributing to the pervasiveness of cross generational sex in Sierra Leone include the low status of women and high economic dependency on men, and the accompanying implication of having to exchange sex for money or favours and low literacy levels especially among women.
3	Implications	The aforementioned factors could jeopardize major public health gains made in the past years as the country strides to meet the MDG in 2015 by maintaining zero new infections. The practice exposes women to coerced sex and also puts young women and men at risk of HIV and other STIs as well as increasing early child bearing. It also contributes to early school leaving by girls if they become pregnant or get married, contributing to low literacy levels among women in the country exacerbating and gender inequalities.
4	Behavioural objectives	• To reduce the number of women and girls engaged in cross generational and inter generational sex • To increase the number of young women consistently and correctly using condoms • To increase the personal risk perception among young women and girls engaged in cross-generational sex
5	Communication objectives	• To inform and educate young women and girls of the risks of engaging in cross-generational sex • To promote the dual benefits of condom use of young women • To discourage cross-generational sex
6	Target audiences	**Primary Audience**: Adults, particularly young women and older men, young people (15-24), in-school and out-of-school youths, MARPS **Secondary Audience**: Peer educators/animators, outreach workers, teachers, Sowies and TBAs, traditional/religious leaders, policy makers
7	Proposed key messages	• Cross-generational sex can leave women disempowered • Cross-generational sex decreases girls' chance of completing school • Cross-generational sex exposes women and girls' to HIV and STIs • The more sexual partners, the higher the risk for HIV infection • Do not give your body for favours
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 11: Sexual and Gender-Based Violence

SEXUAL AND GENDER-BASED VIOLENCE		
1	**Problem statement**	Sierra Leone suffers from high levels of sexual violence and apart from this being a stand-alone problem, it also poses threats to HIV prevention. Sexual violence can take many forms, including rape, child molestation and wife battering. More women than men (over a third compared to a quarter) believe that a women is not justified in refusing sex to her husband, implying that many women themselves are complicit in such acts. Child molestation by elderly family members and rape often are extremely disempowering situations, with the survivor having little chance of negotiating safe sex.
2	**Factors influencing behaviour**	Many of the problems and issues surrounding sexual violence can be attributed to the low level of literacy in the country, particularly in the rural areas. Negative cultural norms and beliefs also play a vital role. Culturally, it is wrong for a woman to refuse to have sex with her husband; if she attempts, the husband's reaction could be violent. Such violence is to a large extent condoned by society. There is also a culture of silence on sexual matters. For example, it is inappropriate to be aware of sexuality before adulthood or marriage. Another driver of sexual violence is economic dependency/insecurity. Women have less access to and control over economic assets, and fewer options for income generation or assets creation, leading to greater vulnerability and the accompanying implication of having to exchange sex for money or favours. Men and women have little or no knowledge about gender laws and there is an overwhelming lack of legal recourse or fear or punishment. Culturally, it is a taboo for a woman to take her husband to court.
3	**Implications**	Apart from the obvious psychological and physiological damage, sexual violence increases the risk of HIV transmission, particularly because one of the partners is not in a position to initiate condom use. Lack of economic empowerment and higher levels of poverty among women leads women to exchange sex for money or favours, thus exposing them to HIV.
4	**Behavioural objectives**	• To reduce number young women and girls who suffer incidences of sexual violence • To increase the number of survivors who access services • To reduce the number of perpetrators with negative norms and beliefs about the benefits of SGBV
5	**Communication objectives**	• To inform and educate the public about the benefits of gender equity and equality • To promote the existence of laws prohibiting SGBV • To dispel negative norms and beliefs about SGBV
6	**Target audiences**	**Primary Audience**: Men and boys, women and girls **Secondary Audience**: Traditional and religious leaders, teachers, health care workers, Family Support Unit, policy and law makers
7	**Proposed key messages**	• Respect women and girls; there should be no violence against them • Laws exist to protect the rights of women and protect them from sexual violence – the three gender laws • Rape is a punishable offence • Wife battering is a punishable offence
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 12: Drug and Alcohol Abuse

DRUG AND ALCOHOL ABUSE		
1	**Problem statement**	Injecting drug users are an emerging concern for the national HIV response, as their behavioural patterns put them at high risk of HIV transmission. In 2007, 4.8% of drug users surveyed reported an HIV positive status (2007 IDU and non-IDU Report, UNODC) and the Sierra Leone Modes of Transmission Study estimated that IDUs accounted for 1.4% of all new HIV infections in 2008. Almost half (46.7%) reported sharing needles.
2	**Factors influencing behaviour**	Drugs are increasingly more available, particularly in urban areas. This fact, coupled with the increasing urbanization of the population in part explains the rise in drug use. Many IDUs and substance abusers are engaged in commercial sex work, and use drugs and alcohol to enable them to continue their work
3	**Implications**	There is an increased risk of HIV transmission through the high level of needle-sharing among IDUs. Alcohol consumption lowers one's risk perception and reduces the likelihood of the person practicing safe sex.
4	**Behavioural objectives**	• To increase the number of people who reject the use of alcohol and drugs as stimulants for sex • To reduce the number of people engaged in unprotected sex • To increase the number of people with correct information about the modes of HIV transmission
5	**Communication objectives**	• To convey the risks in alcohol abuse • To promote the correct and consistent use of condoms • To discourage the use of needles and sharps • To promote correct information about the modes of HIV transmission
6	**Target audiences**	**Primary Audience**: IDUs, substance abusers **Secondary Audience**: Peer educators/animators, outreach workers, , teachers, health care workers
7	**Proposed key messages**	• Seek early treatment for STIs, to prevent complications • STIs are contracted through unprotected sexual intercourse
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 13: Sexually Transmitted Infections

SEXUALLY TRANSMITTED INFECTIONS		
1	Problem statement	Sexually Transmitted Infections (including HIV) are prevalent among the sexually active population, with just under one in ten reporting to have contracted an STI. 1.8% of women and men 1.1% of men reported to have contracted an STI or HIV, with similar patterns in urban and rural areas. There are currently close to 1,800 health care workers and other service providers trained in STI treatment but this number is due to increase as part of the National Strategic Plan on HIV.
2	Factors influencing behaviour	The high prevalence of people engaging in multiple concurrent sexual partnerships without consistently and correctly using a condom is a major contributing factor to the high level of STIs. Generally low levels of condom use and difficulty in accessing condoms are also significant issues. The public have a low level of knowledge on STIs.
3	Implications	Increased infertility, ectopic pregnancy, urethral strictures, blindness in children born to untreated women and HIV transmission are all potential threats as a result of the high prevalence of STIs
4	Behavioural objectives	• To increase the number of people with knowledge of the risks of STIs • To reduce the number of people who acquire STIs • To increase the number of people who seek early treatment of STIs
5	Communication objectives	• To convey information about the risks of STIs • To promote the correct and consistent use of condoms • To promote the benefits of early STIs treatment
6	Target audiences	**Primary Audience**: Adults, Young people (15-24), in-school and out-of-school youths, MARPS, pregnant women **Secondary Audience**: Peer educators/animators, outreach workers, Traditional/religious leaders, teachers, health care workers
7	Proposed key messages	• Seek early treatment for STIs, to prevent complications • STIs are contracted through unprotected sexual intercourse
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 14: Integration of SRH Services

INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES		
1	**Problem statement**	The duplication of some services and gaps in other services exist due to the lack of integration of sexual and reproductive health (SRH) services. Programmes are sometimes set up which could be more efficiently managed by existing institutions.
2	**Factors influencing behaviour**	Factors include poor coordination planning, monitoring, lack of motivation among some health care professionals to create more integrated and efficient services, multiplicity of service providers (government, NGOs, faith-based organisations).
3	**Implications**	The procurement of drugs/supplies and provision of services by different institutions targeting the same beneficiaries leads to wastage of scarce resources (human, financial and material). Monitoring and supervision of ongoing implementation is hindered due to the lack of integration of services.
4	**Behavioural objectives**	• To increase the level of coordination, planning and monitoring in HIV service provision • To increase the number of health personnel trained in SRH and HIV services delivery
5	**Communication objectives**	• To Increase knowledge of the cost implications of parallel service provision • To promote the benefits of coordination, planning and monitoring in HIC service provision
6	**Target audiences**	**Primary Audience**: Government Institutions and Officials, NGOs, **Secondary Audience**: Schools, and other learning institutions Health Providers Partners (Public and Private, Multi-lateral)
7	**Proposed key messages**	• Integration helps to prevent the resources being wasted • Integration eases operations • Integration saves time
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 15: Initiation of Antiretroviral Therapy

INITIATION OF ANTIRETROVIRAL THERAPY		
1	**Problem statement**	Whilst the number of ARV sites has increased to 132, late initiation of ART is still a significant problem in Sierra Leone. The number is well below the 556 HCT sites. Positive patients tested in these sites are referred to other sites with ART facilities. Many people therefore are presented late to the ART facilities and cannot access ART early.
2	**Factors influencing behaviour**	Ignorance about availability of ARVs, lack of access to HIV services and stigma and discrimination contribute significantly to late initiation of ARVs. Negative spiritual messages also affect early ART uptake and adherence. Availability of traditional medicine and faith healing.
3	**Implications**	Increase in the number of patients developing AIDS, high cost in treating opportunistic infections, wastage of the drugs.
4	**Behavioural objectives**	• To increase the number of people who know their HIV status • To increase the number of PLHIVs who initiate ART • To reduced the number of people with stigmatising and discriminatory attitudes towards PLHIVs
5	**Communication objectives**	• To promote the benefits of knowing ones HIV status • To promote the benefits of early Art initiation • To discourage stigma and discrimination against PLHIVs
6	**Target audiences**	**Primary Audience**: Adults, Adolescents, young people (15-24) and in-school and out-of-school youths, MARPS, Traditional/religious leaders **Secondary Audience**: Peer educators/animators, outreach and social workers, political leaders, teachers, health care workers
7	**Proposed key messages**	• ART should be started early for maximum effectiveness • ART can enable HIV positive persons to live healthy and productive lives • ART is free and prolongs your life
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) \ • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 16: HIV/TB co-infection

HIV/TB CO-INFECTION		
1	Problem statement	The HIV/TB co-infection rate is high in Sierra Leone but the level of screening for co-infection is low; less than 1,000 HIV patients have been screened for TB. HIV infection predisposes to TB re-activation or new infection. Multi-drug resistance TB is very common in HIV/TB co-infection. The awareness about TB/HIV co-infection is low among PLHIVs and even healthcare workers.
2	Factors influencing behaviour	Ineffective collaboration of HIV and TB programmes, delay in ART initiation and limited knowledge of healthcare providers about HIV/TB co-infection are some of the factors causing high HIV/TB co-infection.
3	Implications	The implications of TB/HIV co-infection include increased morbidity and mortality, multi-drug resistant TB, drug interactions and increased drug adverse reactions.
4	Behavioural objectives	• To Increase the number of people who know the risks of TB and HIV co-infection • To increase the number of HIV patients testing for TB • To Increased the number of HIV and TB co-infected persons adhering to treatment regime
5	Communication objectives	• To convey the risks associated with HIB and TB co-infection • To promote the benefits of treating HIV and TB • To discourage stigma and discrimination against HIV and Tb patients
6	Target audiences	**Primary Audience**: Adults, young people, in-school and out-of-school youths, MARPS, health care workers **Secondary Audience**: Peer educators/animators, outreach and social workers, political leaders and policy makers, health care workers
7	Proposed key messages	• Take your ART properly to avoid opportunistic infections. • Early ART treatment saves life • For avoid quick die test for HIV and TB, en na free.
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 17: Blood Safety

BLOOD SAFETY		
1	Problem statement	The need for blood is becoming higher with the advent of the Free Healthcare initiative. Blood and blood products however can be a source of HIV transmission. Although only a small number of infections occur as a result of medical injections and blood transfusions, there are reasons for concern. There are only 5 operational Blood Banks in the whole country (3 in the western area and 1 each in Bo and Kenema). The number of Voluntary Blood Donors is low and concentrated in the urban areas.
2	Factors influencing behaviour	In addition to the numerous numbers of myths and misconceptions surrounding blood donation, some people believe that it is ungodly to donate or accept blood. Further, people are asked to pay for blood when they need it, thus creating resentment for the idea of free donation. Voluntary donors have complained about not being well motivated or recognized. Inadequate or lack of facilities to properly store donated creates the transfusion of unsafe blood. Most health instititutions lack facilities to test for HIV (private, stock out). Most cases that arrive at hospitals are emergencies and hence their management causes compromise in the normal procedure.
3	Implications	There is a National Safe Blood Programme in the MOHS. All blood meant for transfusion is screened for Hp, Syphilis and HIV. The lack of sufficient blood banks means that people will have to go a long way to get safe blood and this might lead to a compromise of normal procedure. Parallel transfusion is mostly done leading to HIV infected blood being transfused due to non- detection because of the window period.
4	Behavioural objectives	• To increase the number of people who donate blood • To increase the number of blood units cleaned for transmissible diseases • To reduce the number of people with negative myths and beliefs about blood donation
5	Communication objectives	• To promote the benefits of blood donation • To dispel negative myths relating to blood donation • To inform and educate about modes of HIV transmission
6	Target audiences	**Primary Audience**: Adults, MARPS, in-school and out-of-school youths, political leaders, , traditional/religious leaders and healers **Secondary Audience**: Peer educators/animators, outreach workers, health care workers, teachers
7	Proposed key messages	• Donating blood can save lives • Blood transfusion saves life. • When donating blood, ensure safety precautions are followed
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups (campaigns) • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 18: Resource Mobilization for HIV

RESOURCE MOBILIZATION FOR HIV		
1	Problem statement	Data from NASA indicate that about 95% of HIV funding is from International donors. There is low budget/financial consideration for HIV and AIDS from the government and the private sector. The scarcity of national funds has limited the expansion and sustainability of HIV programmes thus increasing vulnerability of Sierra Leoneans to the epidemic.
2	Factors influencing behaviour	The non-existence of a comprehensive mechanism for mapping organizations that are implementing HIV related activities has limited the coordination role of NAS in supervising and monitoring HIV activities in Sierra Leone. Irregular and untimely production of advocacy messages as a result of lack of a strategy in harmonising advocacy messages on HIV has led to the indiscriminate and inappropriate production of advocacy and IEC materials.
3	Implications	Such a heavy reliance on the Global Fund and indeed on international donors generally leaves HIV programmes vulnerable to collapse as a result of donor fatigue or change in donor priorities. Ultimately this may lead to an increase in HIV prevalence and increased AIDS-related deaths.
4	Behavioural objectives	• To increase the involvement of private sector in HIV activities • To develop a resource mobilization plan • To advocate increased national allocation to HIv serviced provision
5	Communication objectives	• To promote the benefits of private sector commitment to HIV service provision • To promote the significance of increased budget allocation to HIV service provision • To promote benefits of public contribution to HIV service provision
6	Target audiences	**Primary Audience**: Private sector, political leaders, policy makers, NACP
7	Proposed key messages	• Responding to HIV requires a multi-sectoral financial response • Coordination by NAS is necessary for an effective and efficient national HIV response
8	Channels of communication	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

Table 19: Divine Healing of HIV

DIVINE HEALING OF HIV		
1	**Problem statement**	Within some strands of both of Sierra Leone's two main religions (Islam and Christianity), belief in divine healing is promoted as opposed to western medical interventions, i.e. ART. Claims of HIV infected persons becoming HIV negative through prayer are not consistently followed up with an HIV test.
2	**Factors influencing behaviour**	There is high confidence in the power and ability of the religious leaders by their followers. Knowledge about the availability and efficacy of ARVs is low among the general population, and there has been confusion amongst the general public about HIV/AIDS having no cure versus treatment availability". The involvement of the religious community in HIV/AIDS response is also not as strong as it could be. Traditional cultural and spiritual beliefs still have a strong influence on much of the population and these are sometimes merged with Islamic and Christian teaching
3	**Implications**	Failure to initiate or continue ART due to the belief they have been healed can ultimately result in increased AIDS-related deaths. People who believe they have been healed are less likely to practice safe sex which leads to increased new HIV infections.
4	**Behavioural objectives**	• To reduce the number of people who believe in divine healing • To increase the number of people who know that HIV treatment is available medically • To increase the number of religious leaders who preach about the dual approach to treatment (Spiritual and ART)
5	**Communication objectives**	• To promote the benefits of ART • To promote the benefits of the dual approach • To dispel negative myths and beliefs about modes of HIV transmission
6	**Target audiences**	**Primary Audience**: Adults, Young people (15-24), in-school and out-of-school youths, MARPS, traditional and religious leaders/healers **Secondary Audience**: Health care workers, Peer educators/animators, outreach workers
7	**Proposed key messages**	• HIV is a virus, not a moral issue • Uptake of ART is not a sign of lack of faith • Early ART treatment saves life
8	**Channels of communication**	• Interpersonal (one-to-one or small group discussions) • Groups • Print (posters, billboards, newspapers, flyers) and electronic (internet, community, private and government radio, jingles, messages and TV) media.

5.0 Monitoring and Evaluation of the National HIV BCC and Advocacy Strategy

The indicators for monitoring impact and outcome level results are already stated in the National M&E Plan and Strategic Plan on HIV 2011-2015.The output indicators are also worked out in greater details in the M&E plan. However, critical strategic interventions for M&E of the BCC and Advocacy Strategy are:

i. Harmonization and/or alignment of the HIV/AIDS M&E data management systems with the health sector and other implementers for greater efficiency and effectiveness of the overall response.
ii. Popularization of the national targets for service delivery in prevention areas that have been set in M&E Plan.
iii. Strengthening the monitoring and evaluation mechanisms to capture the interventions other than GF supported activities to ensure that achievements of the National response are not understated. This also calls for re-alignment and/or development of new partnerships with stakeholders.

The processes for monitoring and reviewing the prevention strategy are as described below:

(a) Joint Mid-term Review and Final Review of the Prevention Strategy: As already included in the NSP, there will be Joint Mid-term Review of the Prevention Strategy and the Operational Plan to be undertaken in 2013 while the final review will be undertaken in 2015. It will be done with active participation of the stakeholders. A follow-up operational plan covering the last three years of implementation (2013-2015) will be developed.

(b) Joint Supervisory Visits: At periodic intervals there would be joint supervisory visits by the implementing partners, funders, NAS and NACP to programme sites to assess how the programmes are doing and provide the technical support that may be required.

(c) Surveys and surveillance: such as the Behavioural Surveillance Survey (BSS), Demographic Health Survey (DHS), Sexual behavioural Surveys (SBS) will be carried out at specified periods to generate data and provide information on the progress being made in implementing the strategy and whether desired outcomes are being achieved.

(d) Programmatic Reviews: will be carried out periodically to assess progress and address challenges and also plan ahead using programme data. The programmes to be reviewed will include BCC, Condom Promotion, HCT, STI Treatment, PMTCT, Sexual and Reproductive Health, PEP, Injection Safety, and Blood Safety.

(e) Performance Contract Monitoring: NAS signs performance contract with government on annual and quarterly basis. This contract contains the deliverables agreed upon with NAS on annual and quarterly basis, which are monitored on quarterly by the Strategic and Planning Unit of the Office of the President. This is used to track progress that NAS is making in implementing planned activities and also planning for the immediate future as well as putting in place timely corrective measures.

5.1 Strategic Results Framework for Prevention of New Infections

Table 20 below shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that **'Incidence of HIV is reduced by 50% by 2015'**

Three outcomes are expected to contribute to achieving the impact result and they are i) Reduced Sexual Transmission of HIV; ii) Reduction in biomedical transmission of HIV; and iii) Reduction in Mother-to-Child Transmission of HIV.

Outcome 1: Reduced Sexual transmission of HIV

The mode of transmission study suggests that sexual transmission of HIV still account for greatest number of new infections. Furthermore the MARPS account for the greater percentage of new infections through their sexual networks. It follows therefore that reducing the sexual transmission of HIV particularly amongst the MARPs still remains the key pillar for reducing the incidence of HIV.

Three intermediate outcomes will contribute to reduced sexual transmission and they are i) MARPS and clients adopt safe behaviours; ii) reduction of risky sexual behaviour amongst the general population and; iii) increase in quality treatment of STIs.

Table 20: Impact, Outcomes, Intermediary Outcomes and Outputs for Prevention of New Infections

THEME 3: PREVENTION OF NEW INFECTIONS		
IMPACT	**Incidence of HIV is Reduced by 50% by 2015**	
Outcome 1	**Reduced Sexual Transmission of HIV**	
Intermediary Outcome 1.1	**MARPs and clients adopt safe behaviour**	
	Output 1.1.1	MARPs (Female Sex Workers and their clients,, MSM and IDUs) are reached by
	Output 1.1.2	MARPS who know their HIV status
	Output 1.1.3	Condom and other prevention commodities are available and accessible by MARPs
Intermediary Outcome 1.2	**Reduction of Risky sexual behaviour**	
	Output 1.2.1	General Population Reached by Comprehensive Prevention Programmes
	Output 1.2.2	Young People aged 15-24 are at reduced risk of HIV Infection
	Output 1.2.3	People Living with HIV including sero discordant couples provided with positive
	Output 1.2.4	HIV infections resulting from sexual or gender-based violence are prevented
	Output 1.2.5	Increased number of people use condoms correctly and consistently
	Output 1.2.6	Male and Female Condoms are available and accessible by the general populations
	Output 1.2.7	Increased number of people know their HIV status
Intermediary Outcome 1.3	***Increase in Quality Treatment of STIs***	
	Output 1.3.1	Increased awareness of STIs symptoms and demand for STI treatment
	Output 1.3.2	Increased availability and accessibility to high quality STI treatment
	Output 1.3.3	All patients have access to quality family planning services
Outcome 2	**Biomedical transmission of HIV is reduced.**	
	Output 2.1	Universal medical safety precautions is enhanced
	Output 2.2	Increased availability of PEP services in all health facilities
	Output 2.3	All HIV exposed health workers and other cases in need are provided with PEP services
	Output 2.4	All blood donated for transfusion is screened for HIV, Hepatitis and other TTIs
Outcome 3	**Reduction in Vertical Mother-to-Child Transmission of HIV.**	
Intermediary Outcome 3.1	***Reduction in transmission of HIV during pregnancy, child birth and breastfeeding***	
	Output 3.1.1	Increased availability and accessibility of high quality PMTCT services
	Output 3.1.2	All HIV positive pregnant women complete the full PMTCT program
	Output 3.1.3	All HIV exposed infants have access to Early Infant Diagnosis (EID) Services and treatment
Intermediary Outcome 3.2	***HIV positive women are empowered to take informed reproductive health decisions.***	
	Output 3.2.1	HIV Positive women have access to quality family planning services

i) Intermediary Outcome 1.1: MARPS and clients adopt safe behaviours

It is expected that this will be achieved through reaching the MARPS with comprehensive prevention programmes, encouraging them to know their status and ensuring that condom and other prevention commodities are readily available and accessible.

ii) Intermediary outcome 1.2: Reduction of Risky sexual behaviour

This will be achieved through reaching the general population with Comprehensive Prevention Programmes, targeting the young people aged 15-24 with innovative programmes to reduce the risk of new infections, providing positive prevention services to PLHIV and sero-discordant couples, reducing infections from sexual and gender-based violence, increase in the number of people who use condom consistently and correctly as well as availability and accessibility to female and male condoms by the general population.

iii) Intermediary outcome 1.3: Increase in Quality Treatment of STIs

It will be achieved through increased awareness about STIs symptoms and demand for STI treatment, increased availability and accessibility to high quality STI treatment and access to quality family planning services.

Outcome 2: Biomedical transmission of HIV is reduced.

Anecdotal evidence revealed that most health facilities do not practice the universal safety precautions neither do most of them have post exposure prophylaxis in case of medical accidents. Though transmission of HIV through blood transfusion is still very low, most stakeholders said there are rampant cases of unscreened blood transfusion taking place in the rural areas. There is therefore the need to continue to screen all the blood in order to maintain this low level of HIV while encouraging people to also donate blood.

The biomedical transmission of HIV will be reduced through enhancing of the universal safety precautions, increase in availability of PEP services in all health facilities, prompt administration of PEP to exposed health workers and those who need it and screening of all donated blood for HIV and other Transfusion Transmittable Infections (TTIs) such as hepatitis.

Outcome 3: Reduction in Mother-to-Child Transmission of HIV

Studies revealed that the HIV prevalence among women attending ante-natal clinic is 3.2% while that of the general women is population is about 1.5%. The MoT study further shows that mother-to-child transmission of HIV accounts for about 13% of all new HIV infections in Sierra Leone. This clearly shows that mother-to-child transmission is one of most important routes for HIV transmission. Therefore efforts should be made to eliminate the transmission of HIV from infected mothers to their unborn infants.

This outcome will be achieved through two intermediary outcomes: i) Reduction in transmission of HIV during pregnancy, child birth and breastfeeding; and ii) HIV positive women are empowered to take informed reproductive health decisions.

i) Intermediary Outcome 3.1: Reduction in transmission of HIV during pregnancy, child birth and breastfeeding

This will be achieved through: increased availability and accessibility of high quality PMTCT services, completion of full PMTCT program by all HIV positive pregnant women, and ensuring all HIV exposed infants have access to Early Infant Diagnosis (EID) Services and treatment.

ii) Intermediary Outcome 3.2: HIV positive women are empowered to take informed reproductive health decisions.

This will be achieved largely by ensuring that HIV positive women have access to quality family planning services.

Table 21: Indicators for Outcomes and intermediary Outcomes for thematic area 3 with Respective baseline and targets

Nr.	INDICATOR	BASELINE	2013	2015
1.1a	Percentage of MARPs (female sex workers, MSMs, Fisherfolks, Uniformed Personnel) who are HIV infected	Sex Workers- 8.5% MSM-7.5% Uniformed Personnel- 4.4% Fisherfolks- 3.8% (MOT Study- 2010)	Sex Workers- 7% MSM-4% Uniformed Personnel- 4% Fisherfolks- 3%	Sex Workers 5% MSM-4% Uniformed Personnel- 3% Fisherfolks- 3%
1.1.b	Percentage of MARPs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	TBD	60%	80%
1.1c	Percentage of female sex workers reporting the use of a condom with their most recent client	68%, 2005 CSW Study	70%	80%
1.1d	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2010 70%	75%	80%
1.2a	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	15-24yrs women 24.6% Men 11.0% 15-19yrs women 22.3% Men 11.4% 20-24yrs women 26.8% Men 10.5% (SLDHS, 2008)	15-24yrs women 18% Men 8% 15-19yrs women 16% Men 9% 20-24yrs women 18% Men 8%	15-24yrs women 13% Men 5% 15-19yrs women 11% Men 6% 20-24yrs women 13% Men 5%
1.2b	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	15-24yrs women 23.7% Men 32.9% 15-49yrs women 19.7% Men 31.2% SLDHS, 2008	15-24yrs women 30% Men 40% 15-49yrs women 30% Men 40%	15-24yrs women 50% Men 60% 15-49yrs women 40% Men 60%
1.2c	Percentage of population aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex)	15-49yrs women 4.9% Men 20.8% 15-24yrs Women 6.4% Men 18.9% (SLDHS, 2008)	15-49yrs women 3% Men 15% 15-24yrs women 4% Men 12%	15-49yrs women 2% Men 10% 15-24yrs women 3% Men 9%
1.2d	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	15-49yrs women 6.8% Men15.2% 15-24yrs women 12.2% Men 29.2% (SLDHS, 2008)	15-49yrs women 30% Men 40% 15-24yrs women 30% Men 40%	15-49yrs women 50% Men 60% 15-24yrs women 50% Men 60%
1.3a	Percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services (disaggregated by sex)	women 41%, men 54% (SLDHS, 2008)	women 60%, men 60%	women 80%, men 80%
2a	Percentage of people in the general population reporting that last injection was given with a syringe and needle taken from a new, unopened package	women 95.8%, men 93.1% (SLDHS, 2008)	women 96%, men 96%	women 96%, men 96%
2b	Percentage of donated blood units screened for HIV in a quality assured manner	100%, NAS Report 2009	100%	100%
3.1	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	56% NAS Report 2010	60%	80%
3.2	Percentage of women of reproductive age attending HIV care and treatment services whose needs for family planning were met.	TBD	40% increased from baseline	60% increase from baseline

5.2 Strategic Results Framework for Treatment of HIV

Table 22 shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that **'Morbidity and mortality among PLHIVs are reduced by 2015'.**

The impact result will be achieved through the following outcomes: i) Adult PLHIVs and Children PLHIVs eligible for ART receive it; ii) PLHIVs receive OI prophylaxis, treatment and other co-infection treatment.

Table 22: Impact, Outcomes, and Outputs for Treatment of HIV and other Related Conditions

THEME 4: TREATMENT OF HIV AND OTHER RELATED CONDITIONS		
IMPACT	**Morbidity and mortality among People Living with HIV (PLHIVs) are reduced**	
Outcome 1	**Adult PLHIVs and Children PLHIVs eligible for ART receive it.**	
	Output 1.1	Increase in eligible PLHIV identified in order to initiate treatment
	Output 1.2	Improved HIV exposed Infant follow-up according to national guidelines
	Output 1.3	Coverage of facilities offering ART is increased
	Output 1.4	Quality Standards for ART are maintained
Outcome 2	**PLHIVs receive OI prophylaxis, treatment and other co-infection treatment by 2015**	
	Output 2.1	PLHIVs receive OI and other co-infections prophylaxis and treatment according to need
	Output 2.2	PLHIVs with STIs receive treatment for STIs
	Output 2.3	PLHIVs with HIV and TB receive appropriate treatment for TB

Outcome 1: Adult and Children PLHIVs eligible for ART receive it.

This outcome is critical to achieving the impact results as evidences abound indicate that only 52% of adults who are eligible for ARV receive it. It is even worse for the children as only 5% of those eligible are receiving it.

The outcome will be achieved through: i) Increase in eligible PLHIV identified in order to initiate treatment; ii) Improved HIV exposed Infant follow-up according to national guidelines; iii) Coverage of facilities offering ART is increased; and iv) Quality Standards for ART are maintained.

Outcome 2: PLHIVs receive OI prophylaxis, treatment and other co-infection treatment

This will be achieved through; PLHIVs receiving OI and other co-infections prophylaxis and treatment according to need, PLHIVs with STIs receive treatment for STIs and PLHIVs with HIV and TB receive appropriate treatment for TB.

Table 23: Indicators for Outcomes for thematic area 4 with Respective baseline and targets

No.	INDICATOR	BASELINE	2013	2015
1	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2010 - Adults 52% 2010 - Children 5%	Adults 60% Children 60%	Adults 80% Children 100%
2a	Percentage of people enrolled in HIV care and treatment who receive cotrimoxazole prophylaxis in the last 12 months	TBD	60%	80%
2b	Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	23%, (NAS Report 2010)	60%	80%
2c	Percentage of hospitals and health centres offering full package of HIV services (HCT, PMTCT, ART, TB)	2010 53%	70%	80%

6.0 Cost Summary of the National HIV BCC and Advocacy Strategy

The total budget five year budget for the implementation of the Prevention Strategy is USD 106.5million accounting for 33% of the total (USD322 million) AIDS response resource needs. Within the broad Prevention category, 50% (USD53.6 million) of the resource requirements are for service delivery (condom promotion, PMTCT, VCCT, STI and mass media) 41% (USD 43.7 million) for priority populations -MARPs, community mobilization and workplace activities. The remaining 9% (USD 9.3 million) is earmarked for health care delivery such as PEP, blood safety, universal precaution and injection safety.

Table 24: Cost Summary of Resource for the AIDS Response in Sierra Leone 2011-2015

Cost summary	2011	2012	2013	2014	2015	Totals	%
Prevention	8.3	14.1	20.1	26.9	37.2	106.5	**33%**
Treatment	7.2	14.4	24.3	36.5	51.4	133.8	**42%**
Care and support	1.1	1.9	3.1	4.5	6.2	16.9	**5%**
Mitigation for PLHIVs / OVC	2.4	4.5	6.4	8.0	8.9	30.3	**9%**
Policy, admin., research, M&E	2.3	4.2	6.5	9.1	12.5	34.5	**11%**
Total Millions of USD	**21.2**	**39.1**	**60.5**	**85.0**	**116.2**	**322.0**	**100%**
Total Millions of Leones	**81,743.1**	**150,613.3**	**232,850.6**	**327,066.6**	**447,515.2**	**1,239,788.7**	

Note: Adapted from the National Strategic Plan for HIV 2011-2015, Page 52-54

Table 25: Prevention Cost Breakdown for the AIDS Response in Sierra Leone 2011-2015

SERVICE DELIVERY AREA/YEAR	2011	2012	2013	2014	2015	Totals
Prevention	**8.3**	**14.1**	**20.1**	**26.9**	**37.2**	**106.5**
Priority populations						***43.7***
Youth focused interventions	0.3	0.6	1.0	1.5	2.0	5.5
Female sex workers and clients	0.2	0.6	1.1	1.8	2.7	6.5
Other MARPs (MSMs, IDUs, clients)	1.1	2.7	3.7	4.2	7.0	18.7
Workplace	0.5	1.0	1.8	2.7	3.8	9.7
Community mobilization	0.3	0.5	0.6	0.8	1.1	3.3
Service delivery						***53.6***
Condom provision	3.3	5.0	7.1	9.6	12.7	37.6
STI management	0.44	0.5	0.7	0.8	0.9	3.4
VCT	0.7	1.0	1.4	1.8	2.4	7.3
PMTCT	0.2	0.4	0.5	0.7	1.0	2.8
Mass media	0.4	0.4	0.5	0.5	0.6	2.5
Health care						***9.3***
Blood safety	0.6	0.8	1.1	1.5	1.9	5.9
Post-exposure prophylaxis	0.21	0.33	0.46	0.63	0.82	2.4
Safe injection	0.01	0.01	0.01	0.01	0.01	0.1
Universal precautions	0.1	0.1	0.2	0.2	0.3	0.9

Note: Adapted from the National Strategic Plan for HIV 2011-2015, Page 52-54

6.1 Cost Summary Breakdown of the Behaviour Change Communication

The total average five-year (2011-2015) budget for implementation of the Behaviour Change Communication and Advocacy Strategy is USD 7.15million. The area of greatest expenditure is Voluntary Counseling and Testing, with an annual budget of USD 390,000, followed by Mass Media, at USD 220,000. MARPs (IDUs, Sex workers and clients, and MSM) and Prevention programs for PLHIVs are each indicated in the budget.

Table 26: Behaviour Change Communication Cost Breakdown for the AIDS Response in Sierra Leone 2011-2015

Costs by Function	Annual Cost (USD)	Five-Year Average Cost (USD)
Behaviour Change Communication		
1.01. Mass Media	220,000	1,100,000
1.02. Community mobilization	150,000	750,000
1.03. Voluntary counseling and testing	390,000	1,950,000
1.04. Special populations	10,000	50,000
1.05. Youth in school	160,000	800,000
1.06. Youth out of school	210,000	1,050,000
1.07. Prevention programs for people living with HIV	130,000	650,000
1.08. Programs focused on sex workers and their clients	30,000	150,000
1.09. Programs focused on MSM	30,000	150,000
1.10. Harm reduction programs for IDUs	20,000	100,000
1.11. Workplace Activities	80,000	400,000
Total	**1,430,000**	**7,150,000**

Note: Adpated from the ASAP costing model for Operational Plan for HIV 2011-2015,

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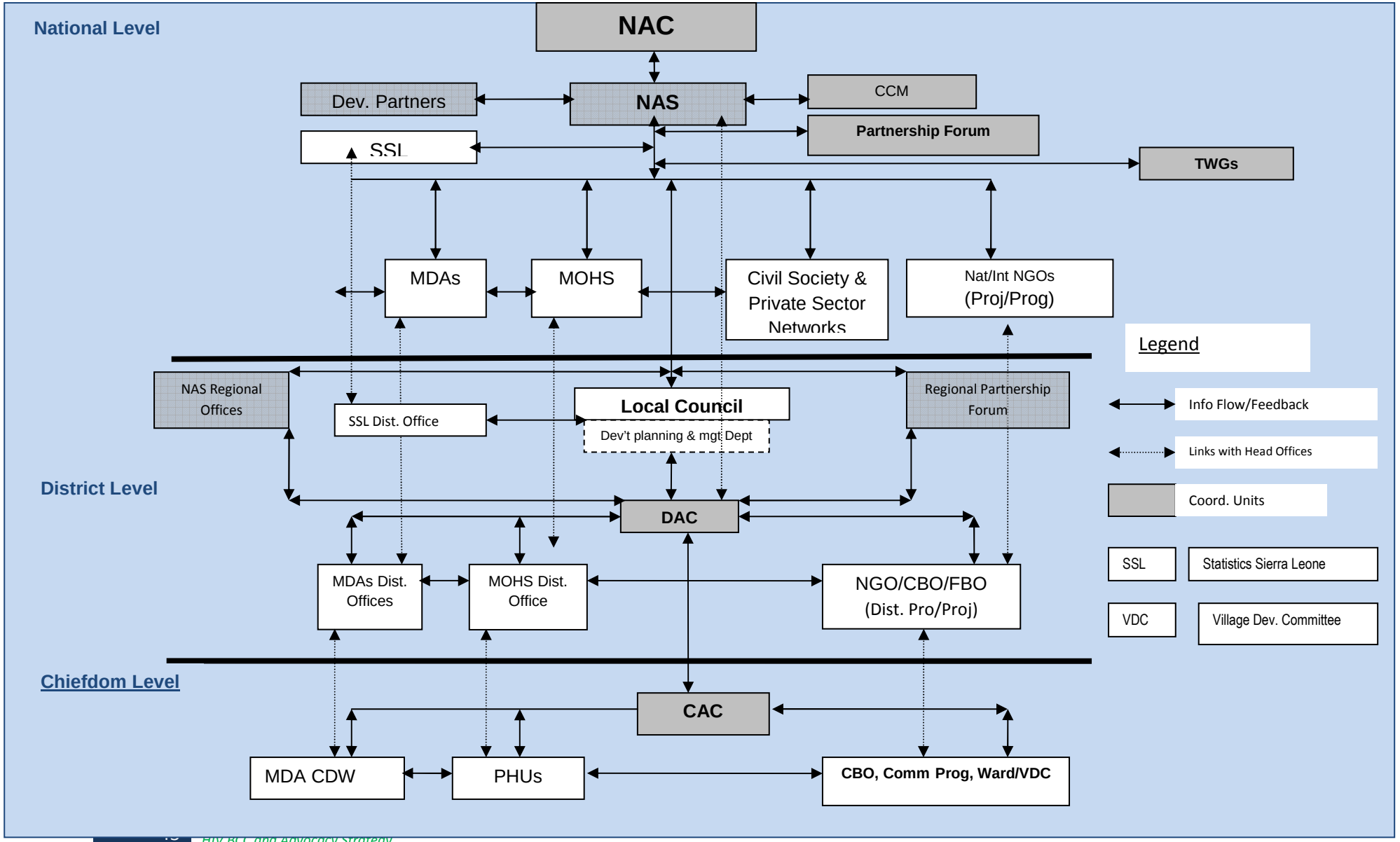
ANNEX I: INSTITUTIONAL FRAMEWORK FOR COORDINATION AND IMPLEMENTATION



ANNEX II: Inventory of BCC Materials used to date

No	Message	Supporting message	Type
1	AIDS Can Get You Totally Wasted		Bill Board
2	I am Mr. Condom	Get me Use me. I will protect you from HIV and AIDS	Poster/Bill
3	No Condom No Sex		Poster
4	HIV Today, AIDS Tomorrow		Poster
5	Say No to Sex		Poster
6	Get a Healthy baby	Get Tested for HIV during pregnancy	Poster
7	I am Living positively with HIV.	I take my treatment regularly	Poster
8	Help protect your baby.	Get tested for HIV	Poster
9	HIV is real in the workplace.	Let's talk about HIV and AIDS	Poster
10	Say No to HIV and AIDS Stigma and discrimination	We are colleagues even with HIV and AIDS	Poster
11	Help protect your baby.	Get tested for HIV during pregnancy	Poster
13	Uniting the World against AIDS		Poster
14	Towards Zero New HIV Infection	Get Tested	Poster
15	Together we can save lives		Poster
16	Deal with it at work place	Protect rights, support prevention, .ensure care,	Poster
17	AIDS is Here	Join us to stop it	Poster
18	Our future is in your hands Keep it AIDS free.	Abstinence, Be faithful Use condoms	Poster
19	Be faithful to your partner		Poster
22	Only you can stop AIDS		Poster
23	Fight HIV/AIDS	Talk to your peers and know how to protect your	poster
24	AIDS is here and Real	Say no to sex, abstain from sex	
25	United against AIDS		Poster
26	The Lord God Almighty has given us a marvelous life. In combat we rely on our comrades to watch over us	It is our responsibility to help them, prevent HIV&AIDS	Poster
27	HIV/AIDS You can prevent it,	Do not share blades, needles, syringes or any sharp	Poster
28	Take the lead, take the HIV test	Get tested for HIV.	Poster
29	Take the lead to stop AIDS	Get tested	Poster
30	HIV and AIDS Treatment	HIV is Preventable, AIDS is Treatable with ARVs	Brochure
31	HIV & AIDS. What you need to Know	Only You Can Stop AIDS. So Take Care of Yourself and	Brochure
32	HIV/AIDS Information Leaflet for Muslim Youths		Brochure
33	HIV VCCT		Brochure
34	HIV & AIDS Basic Facts	Take Care of yourself and those you love	Brochure
35	HIV/AIDS Stigma and Discrimination	Do not Stigmatize, Stigma can Kill Faster Than the	Brochure
36	Prevention of Mother to Child Transmission	All Pregnant women must attend Antenatal Clinics	Brochure
37	Prevention of Mother to Child Transmission.	Know the Facts	Brochure
38	Female Condom its nice, its safe	It protects against HIV and AIDS	Sticker
39	Only You Can Stop AIDS		Sticker
40	HIV doesn't mean rejection at work	Our workplace policy forbids stigma and	Sticker
41	Only you can stop AIDS		Sticker
42	HIV is a virus… Not a Moral Issue	S.A.V.E	Hand Bill
43	Stop AIDS.. Keep the Promise	Take the lead …Take the HIV Test	File folder

Annex III: Inception Drafting Workshop for the Core Group, –September 4-10, Taiama, Moyamba District

NO.	NAME	INSTITUTION
1.	James M. Fofanah	Restless Development
2.	Abdul H. Sankoh	MOHS
3.	Lansana Conteh	MOHS
4.	Mohamed K. Sandi	NAS
5.	Hudson Tucker	Global Rights
6.	Moi Tenga Sartie	NAS
7.	Susan Tucker	NACP
8.	Idrissa Songo	NETHIPS
9.	Mariama M. Conteh	NACP
10.	Sullay Lakoh	MOHS
11.	Sulaiman K. Fogbawa	CARE
12.	Abu B. B. Koroma	NAS
13.	Abdul Rahman Sessay	NAS
14	Nyaibor Ngombu	UNFPA
15	Jusu Squire	UNFPA
16	Adama Thorlie	UNDP
17	Chibwe Lwamba	UNAIDS
18	Helen Lane	UNAIDS
19	Edmond Makiu	UNICEF
20	Kalilu Totangi	Consultant
21	Dominic Lamin	Consultant

Annex IV: Consultation with the District and City Councils, October 17 – 18, 2011, Bo.

NO.	NAME	INSTITUTION
1.	Henry K. Martin	Bonthe Municipal Council
2.	Dalton K. Charles	Bonthe Municipal Council
3.	Julia T. Amara	Bo District Council
4.	Remie Musa	Bo District Council
5.	Tahim Fullah	Pujehun District Council
6.	Mohamed S. Salifu	Pujehun District Council
7.	Namisa Kramer	NAS Regional Office, Bo
8.	Gabriel T. Ndanema	Moyamba District Council
9.	Thomas Brima	Bo City Council
10.	Mary J. Coker	Bo City Council
11.	Ansu Feika	Bonthe District Council
12.	Sheku A. Sheriff	Bonthe District Council
13.	Thaim S. Kargbo	NAS Regional Office, Bo
14.	Eric M. Sam	Kailahun District Council
15.	Edward Alpha	Koidu New Sembehun City Council
16.	Ahmed Samba Turay	Freetown City Council
17.	Ramata Mansaray	Tonkolili District Council
18.	Arthur Allieu	Tonkolili District Council
19.	Alimany B. L. Mansaray	Kono District Council
20.	David Sesay	NAS Regional Office, Makeni
21.	Thaimu s. Kanu	Western Area Rural District Council
22.	Abioseh Mansaray	Western Area Rural District Council
23.	Abdul Karim Marah	Freetown City Council
24.	Mohamed M. B. Sisay	NAS Regional Office, Kenema
25.	Augustine K. Luseni	NAS Regional Office, Kenema
26.	Fatmata Dassama	Kenema District Council
27.	Fatmata Sannoh	Kailahun District Council
28.	Junisa Jamiru	Kono District Council
29.	Alie B. Mansaray	Kono District Council
30.	Komba L. Wonneh	Koidu New Sembehun City Council
31.	M. S. Conteh	Kenema City Council
32.	Afiju Pokawa	Kenema District Council
33.	Anthony Fonnie	Kenema City Council
34.	Mohamed B. Jalloh	Kambia District Council
35.	Abu Salia Kamara	Kambia District Council
36.	Isatu Mansaray	Makeni City Council
37.	Nyuma Manigo	Makeni City Council
38.	Frank Kanu	Bo District Council
39.	Alhassan Kamara	NAS Regional Office, Makeni
40.	Abdul Rahman Sesay	NAS Headquarters
41.	Abu B. B. Kamara	NAS Headquarters
42.	Joseph Samura	Makeni City Council
43.	Arnold Mason	Bonthe Municipal Council
44.	Joseph Tholley	Tonkolili District Council
45.	Chibwe Lwamba	UNAIDS
46	Aki Yoshino	UNAIDS
47	Edmond Makiu	UNICEF
48	Salieu Jalloh	UNICEF
49	Dominic Lamin	Consultant
50	Kalilu Totangi	Consultant

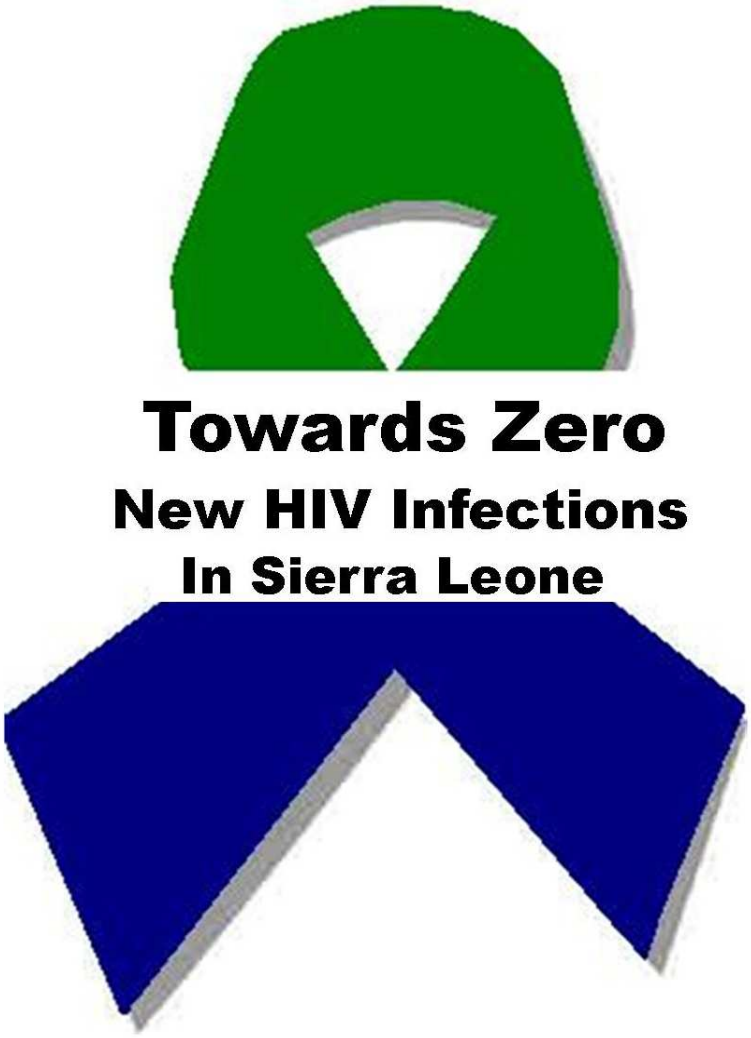
Annex V: Consultation with Young People, -October 27, 2011, Freetown

No.	Name	Organization
1.	Ibrahim Mansaray	Artist United for Children and Youth Development in Sierra Leone
2.	George R. Freeman	Why can't we get married.com
3.	George D. Morris	Youth Action for Development
4.	Hajie Bah	Network Movement for Youths – Sierra Leone
5.	Yamarie Jah	Youth & Children Advocacy – Advocacy Network
6.	Ernest H. Aruna	Restless Development
7.	Fatmata Sall	AIESEC – Sierra Leone
8.	Princess Owiredu	Young Potential Forum Network
9.	Sheku Kamara	Young Potential Forum Network
10.	Kenneth M. Libby	Restless Development
11.	Helen Lane	UNAIDS
12.	Alimamy S. Kargbo	Sierra Leone Youth Coalition on HIV/AIDS (SLYCHA)
13.	Idrissa A. Conteh	Sierra Leone Youth Coalition against AIDS
14.	Leslie A. A. Sesay	Young Potential Forum Network
15.	Samuel Makiu	UNICEF
16.	Alusine J. L. Rogers	Action for Social Rights (AfSOR)
17.	Mohamed B. Koroma	Sierra Leone Youth AIDS Network (SILYAN)
18.	Mariama Bangura	United Nations of Youths
19.	Regina Lumeh	Restless Development
20.	Daniel F. H. Keita	Restless Development
21.	Abrahman Bah	Free Your Mind
22.	Abdul Rahman Sessay	NAS
23.	Aminata Shaw Korjie	NACP
24	Abu Bakarr Koroma	NAS
25.	Kalilu Totangi	Consultant
26	Dominic Lamin	Consultant

Annex VI: National Validation Workshop, – 9th November 2011, Freetown .

NO.	NAME	INSTITUTION
1.	Lillian B. Khanu	Business Coalition Against AIDS in Sierra Leone
2.	Alpha Y. Kargbo	HIV/AIDS Reporters Association
3.	Doris Bah	Sierra Leone Inter Religious Network on AIDS
4.	Rev. Christiana Sutton-Koroma	Sierra Leone Inter Religious Network on AIDS
5.	Sylvester W. E. Bell	Business Coalition Against AIDS in Sierra Leone
6.	Samuel R. Hyde	Business Coalition Against AIDS in Sierra Leone
7.	Dr. Sulaiman Conteh	NACP
8.	Brima Sorie Kanu	Network of HIV Positives in Sierra Leone (NETHIPS)
9.	Hon. Marie Jalloh	Parliamentary Committee on HIV HIV/AIDS
10.	Veronica Smith	AFRICARE
11.	Saffa Smart	AFRICARE
12.	Dominic Lamin	Consultant
13.	Komba Fillie	HIV/AIDS Reporters Association
14.	James M. Fornah	Restless Development
15.	Farai Moronzi	Restless Development
16.	Sulaiman K. Fogbawa	CARE
17.	Hawanatu Bangura	Rofuntha Development Association (RODA)
18.	Samuel R. Thulla	Network of HIV Positives in Sierra Leone (NETHIPS)
19.	Idrissa Songo	Network of HIV Positives in Sierra Leone (NETHIPS)
20.	Alhaji Teslim Alghalie	Sierra Leone Inter Religious Network on AIDS
21.	Lansana Conteh	MOHS
22.	Dr. Maxim Conjoh	MMCET
23.	Mohamed K. Sandi	NAS
24.	Martha S. Kamara	NACP
25.	Sieh Sesay	ORIENT
26.	Sulaiman S. Kamara	Cultural Jazz Union
27.	Dilys Thompson	NAS
28.	Dr. Saidou Hangandombou	NAS
29.	Arnold Macauley	Network of HIV Positives in Sierra Leone (NETHIPS)
30.	Moi Tenga Sartie	NAS
31.	Fatiejay Kamara	NAS
32.	Kalilu Totangi	Consultant
33.	Marie Benjamin	Society for Women and AIDS (SWAASL)
34.	Betty Alpha	UNFPA
35.	Marian Kargbo	Aureol Insurance Company
36.	Lansana Conteh	MOHS
37	Musu A Jimmy	Voice of Women
38	Mohamed Kutubu	COOPASL
39	Chibwe Lwamba	UNAIDS
40	Dr. Dorothy Ochola-Odongo	UNICEF
41	Mulunesh Tennangashaw	UNAIDS
42	Salieu Jalloh	UNICEF
43	Edmond Makiu	UNICEF
44	Akie Yoshino	UNAIDS
45	Helen Lane	UNAIDS
46	Mamby Yarjah	UNAIDS
47.	Abdul Rahman Sessay	NAS
48.	Tunie M. Kargbo	NAS
49.	Donald M. Charles	NAS
50.	Mohamed S. Sannoh	NAS

National HIV Behaviour Change Communication & Advocacy Strategy 2011-2015



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